Antonio H. Reza DDS Family Dentistry

INFORMATION ON PROCEDURES AND INFORMED CONSENT FOR MINOR

We are committed to providing the highest quality dentistry which will assist our patients in achieving excellent dental health. Because we believe in our patients being well educated and well informed about their dental care, an explanation of procedures should include a discussion of the possible complications. This form lists most of the possible complications that can occur with dental treatment, and we welcome your discussion and any questions about any aspect of your dental care.

Minor's Name: ____

Parent/Guardian's Name: __________________________________

Treatment date of service: ________________________________

*****Please sign the applicable line below for the minor patient to have scheduled treatment in our office without a parent or guardian present and send with patient to appointment*****

If patient is coming in for regular hygiene recall please fill in the portions below and disregard the remainder of the form:

I, ____ give __________________________________ permission to have a regular prophylaxis (cleaning), periodic evaluation (exam), radiographs (x-rays), and fluoride treatment (if applicable) for appointment date _______________ .

Signature of Parent/Guardian:____

Please make any notes from parent/guardian to provider here:

<u>Drugs and Medications:</u>

I understand that drugs and medications such as antibiotics and analgesics and other prescription drugs may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol and/or other drugs. Therefore, I agree not to operate any vehicle, automobile, or hazardous device, or work, while taking any drug or medication that may affect my performance. I also understand that drugs and medications can cause allergic reactions causing redness and swelling or tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Some antibiotics may affect the performance of birth control pills or may react to sunlight.

I agree to contact my primary care physician (or specialist or other medical professionals if appropriate) regarding any active medical condition that I have which may be influenced or be affected by dental treatment, drugs or medications (i.e., pregnancy, nursing, diabetes, heart problems, etc.).

Complications from local anesthetic (lidocaine, etc.) are uncommon, but may include the following: prolonged soreness, ulceration, infection of the injection site, temporary inability to open your mouth wide (restricted opening), feeling of light-headedness or nausea, the sensation of heart palpitations (epinephrine rush), difficulty breathing and (rarely) injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lips, teeth, or gums that may persist for several weeks, months, or permanently.

Parent/Guardian Signature for Procedure:___________________________________

Date:______________________

Periodontal (Gum) Disease:

I understand that I have been advised that I have periodontal (gum) disease. This is a serious condition of bacterial infection of the gum and/or bone and may lead to the loss of several or all of my teeth. Periodontal disease treatment can range from: regular maintenance (prophylaxis) hygiene sessions to quadrant "deep cleanings" (root planings or gingival curettage) with anesthetic, to referral to a Periodontist for evaluation and treatment, or extractions; or a combination of these. The recommended treatment for my own periodontal disease has been explained to me in a manner in which I understand. On most Periodontal disease treatments, I understand that I will likely experience post-treatment soreness.

Parent/Guardian Signature for Procedure:___________________________________

Date:______________________

Restorations: Fillings, Crowns, and Bridges:

I understand that the diagnosed fillings, crown, and/or bridges will be restored with the materials discussed at the examination visit (silver, tooth-colored composite, temporary material, porcelain, or gold crowns). I will be responsible to ask any questions about the materials and/or process of doing any restorations to my satisfaction at any time I think of them. The size of the fillings may change (may become smaller or larger), or a different restorative material may be recommended during the treatment due to additional or unseen decay or structural weakness that could not be foreseen prior to treatment. Any changes will be discussed as soon as possible with the parent by way of phone call. Teeth that have routine restorative procedures performed (temporaries, fillings, crowns, etc.) will be sensitive after treatment. This sensitivity of discomfort varies from patient to patient and may last from 2-3 weeks up to or beyond 6-8 weeks. I realize that if this sensitivity does not decrease and disappear, I may need additional treatment to the tooth, the most common being root canal therapy.

I understand that the objective is to achieve natural and "life-like" restorations but I understand that sometimes it is not possible to perfectly match the color of natural teeth with artificial restorations. I realize that I may be wearing temporary fillings or crowns, which may come off easily, and that I must be careful to keep them intact until the permanent crowns or filings are completed. The final opportunity to make changes

in color or shape of my crown or bridge will be before the final cementation. Fillings or crowns that are constructed to fit under or with existing prosthetics (partial or complete dentures) may alter the fit of the feel of the prosthesis, resulting in the necessity for adjustments, relines, or the construction of new appliances which will be the patient's responsibility.

Parent/Guardian Signature for Procedure:____________________________________

Date:______________________

Endodontic Therapy (Root Canal Treatment):

I realize that there is no guarantee that Root Canal Therapy will save my tooth (or teeth). Complications can occur before, during, and after treatment, such as infection, swelling and pain. Additional possible complications include blocked or untreatable canals (calcified), fractured teeth or roots, broken files, short or long fills, and the possibility of the need for additional surgical procedures (apicoectomy) or extraction. The fee for the Root Canal Therapy does not include the final permanent restorations (since this restoration can range from single surface filling to a crown with post and core build up or bridge.)

Parent/Guardian Signature for Procedure:____________________________________

Date:______________________

Cosmetic Procedures:

I understand that the cosmetic procedures recommended to me are considered optional treatment and probably will not be reimbursed by any insurance company or employee benefit plan. I understand the purpose and nature of the type of treatment to be performed which may include bonding (or tooth colored restorations), porcelain veneers or inlays or crowns. I realize that no guarantee may be given as to the appearance, results, or longevity of such treatment. I understand the basic limitations of such treatment which may include staining or discoloration, chipping, wear or abrasion, sensitivity, loss or loosening, fracture of the restoration or of the tooth, and receding gum tissue. I understand it is my responsibility for the proper professional examinations and preventative care.

Parent/Guardian Signature for Procedure:____________________________________

Date:______________________

Surgical Procedures and Extractions (Removal of Teeth and Tissue):

Alternatives to removal have been explained to me (root canal therapy, crowns, fillings and/or periodontal surgery, etc.). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Operative risks include, but are not limited to: discomfort (pain), swelling, bleeding (which may be prolonged), injuries to adjacent teeth and restorations, dry sockets, stretching of the corners of the mouth with resultant cracking, bruising, restricted mouth opening for several days or weeks, decision to leave a small piece of root in the jaw, fracture of the jaw, injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lips, gums, and/or tongue that may persist for several weeks, months, or permanently, opening of the sinus (oral-antral fistula) requiring referral to a

specialist or additional surgery, and creating or exacerbating pain or clicking in the jaw joints (temporomandibular joint disorders, TMJ).

Parent/Guardian Signature for Procedure:___________________________________

Date:______________________

Completion of Treatment:

I understand the risks of not having the diagnosed treatment performed in a timely manner, the most common being the worsening of my dental health resulting in additional or more extensive treatment being required. I agree to complete each multiple step procedure in a timely manner so to reduce the risk of complications or unsuccessful treatment. (Example: crown preparation and delivery root canal opening and sealing, denture impression and delivery, temporary and permanent restorations, etc.). I further agree to return for post-operative appointments and continuing care visits s deemed necessary by the dentist for the maintenance of my dental health. In addition, I understand that the treatment not completed within 6 months of the start of treatment may be subject to an increase in fees.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and it individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment. I agree to ask the dentist if I have any questions regarding this consent form, or if I do not understand any aspect of it, or the dentistry diagnosed.

Parent/Guardian Signature for Procedure:___________________________________

Date:______________________