NOVELLY FAMILY
Dentistry & Orthodontics

GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

1. **WORK TO BE DONE**: I understand that I am having the following work done [Indicate all services being provided]: Fillings (), Bridges ( ), Crowns ( ), X-rays ( ), Extractions (), Impacted teeth removal (), Root Canals ( ), Dentures ( ), Other ( )

Patient Initials _____

2. **Consent to Treat Minor Without Parent/Guardian Present:**
I understand that I may choose to leave the dental office while my minor child is receiving treatment. By doing so, I authorize the doctors and staff at this practice to evaluate, diagnose, and provide the planned dental treatment to my child in my absence. I understand that the dental team will use their professional judgment to determine if additional treatment becomes necessary during the appointment. If unforeseen treatment beyond what has been discussed is recommended, the office will make reasonable efforts to contact me for authorization before proceeding, except in situations where delaying treatment could compromise my child's health or safety. I accept responsibility for any treatment authorized under this consent.

Patient Initials _____

Parent/Guardian Cell Phone: _____

Alternate Emergency Contact: _____

Phone Number: _____

3. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics, and other medications may cause allergic reactions, causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking before starting dental work may have unforeseen negative consequences for me. ***Patient Initials*** _____

4. **CHANGES IN TREATMENT PLAN:** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures.
I grant my dentist permission to make necessary changes and additions. ***Patient Initials*** _____

5. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the following teeth: _____, and any others necessary for reasons in paragraph #3.

I understand that removing teeth does not always eliminate all the infection, if present, and it may be necessary to undergo further treatment. I understand the risks involved with extraction, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period, and a fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

Patient Initials _____

6. **CROWNS, BRIDGES, AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which can be easily removed, and that I must take care to ensure they remain in place until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 30 days from initial tooth preparation. Excessive delays may allow for tooth movement, which may necessitate a remake of the crown, bridge, or cap. In such instances, I understand that additional charges may apply for remakes due to my delay in permanent cementation. ***Patient Initials*****_____**

7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments, and stresses from their manufacture can cause them to separate during use. I understand that occasionally, additional surgical procedures may be necessary following a root canal treatment (apicoectomy). I understand that the tooth may be lost despite all efforts to save it.

Patient Initials _____

8. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss, and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition. ***Patient Initials***

_____

9. **FILLINGS:** I understand that care must be taken when chewing on fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.

Patient Initials _____

10. **DENTURES:** I understand that the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of dentures immediately after extractions) may be painful. Additionally, immediate dentures often require considerable adjustment and multiple relines. A permanent relining will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for the delivery of the dentures. I understand that failure to keep my delivery appointment may result in indentures that do not fit properly. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.

Patient Initials _____

I understand that dentistry is an inexact science, and therefore, reputable practitioners cannot guarantee results with absolute certainty. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) I have requested and authorized.

I hereby authorize any of the doctors, dental assistants, or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____