INFORMED CONSENT

I hereby give my consent to use local anesthetics, relaxants, anti-inflammatories, antibiotics, antihistamines, steroids, or pain medications if deemed necessary for the completion of any medical or dental treatment.

I hereby grant permission to take photographs of my mouth or head and neck to be used, without revealing my identity, for the furthering of medical and dental knowledge and education, especially for the benefit of other patients and dental professionals.

I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.

I understand that root canal treatment is an attempt to retain a tooth that would otherwise require an extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection and may require retreatment, surgery or (rarely) extraction. Restoration with a crown or a ceramic onlay should always follow a root canal treatment to ensure a good long-term prognosis. Sometimes a post is also indicated.

I understand that preparation of teeth for crowns, bridges, fillings, and onlay/inlays may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on the tooth in the future.

Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill, and render it ineffective against preventing pregnancy.

I realize that any of the treatment that the doctor proposes can also be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the treatment.

Finally, I realize that any costs incurred during treatment are my responsibility. I realize that my insurance may help pay part of my treatment costs and that any estimates of insurance benefits quoted to me are only estimates. I will ultimately be responsible for any balance on my account left unpaid by the insurance company. I understand that I would be charged interest on any unpaid balance at a monthly rate of 1.5%. I also understand that if I am taken to collection, I will be responsible for any attorney fees incurred.

I understand that if I fail to give 24- or 48-hours' notice (dependent upon the type of appointment) to cancel a scheduled/reserved appointment time block, that I will be charged a fee up to the amount of the scheduled appointment procedure. I also understand that any X-rays taken are the property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood- or mind-altering drugs prior to signing this form.

Signed:_____ Date:_____

Patient, Parent, or Guardian