SmileStudio

Informed Consent

1. Work to be done: I understand that I am having the following work done [indicate all services being provided]: Fillings (☐) Bridges (☐) Crowns (☐) SRP (☐) Extractions (☐) Root Canals (☐) Implants (☐) Dentures (☐)
2. Local Anesthetic (☐) Other (☐) _____
   Patient Initials _____

3. Local Anesthesia: There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness that can occur is usually temporary, but in rare instances it could be permanent.

   Additional risks: _____
   Patient initials _____

4. Drugs and medications: 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 any and 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 or changes in my medical information prior to starting dental work may have unforeseen negative consequences for me.

   Additional risks: _____
   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 tooth/teeth:_____. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extractions, some of which are pain, swelling, spread of infection, bone loss, loss/damage to adjacent teeth, dry socket, and loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can be temporary or permanent, and fractured jaw. I understand I may need further treatment by specialist if complications arise during or following treatment.

   Additional risks: _____
   Patient Initials _____

6. Implants: I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following: Postoperative pain, discomfort and swelling, bleeding, postoperative infection, injury or damage to adjacent teeth or roots of the teeth, Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling or pain of the chin, lips, cheek, gums or tongue, Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw — temporomandibular joint (TMJ) syndrome, Fracture of the jaw, Bone loss of the jaw, Penetration into the sinus cavity, Mechanical failure of the anchors, posts, or attached teeth, Failure of implant itself. Although rare, I understand these potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization or blood transfusions I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures.

   Additional risks: _____
   Patient Initials _____

7. Crowns, bridges and caps: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth realize the final opportunity to make changes in my new crowns, bridges, or cap (including shape, fit, and color) will occur only before final cementation. It is possible for a tooth to become sensitive after a crown as the nerve dies. If this takes place, then a root canal may be necessary to do a root canal through the crown.
   Additional risks: _____
   Patient Initials _____

8. Fillings: I understand that a more extensive filling than originally diagnosed may be required due to additional decay. When a composite filling is placed, effort will be made to closely approximate the appearance of natural tooth color. However, because many factors affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, the shade of the composite fillings can change over time because of a variety of factors including mouth fluids, foods, smoking, etc. I understand that increased sensitivity is a common effect of a newly placed filling and can be associated with, but not limited to: nerve damage, high bite. Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity can be mild or severe. The sensitivity may last up to six weeks. If such sensitivity is persistent or lasts for an extended period of time, I will notify the dentist because this can be a sign of more serious problems.

   Additional risks: _____
   Patient initials _____

9. Periodontal disease (tissue and bone): I understand that I am being treated for periodontal disease, this means I have a serious condition, causing gum inflammation and bone 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 my periodontal condition may have a future adverse effect on my dental treatment.
   Additional risks: _____
   Patient initials _____

10. Endodontic treatment (root canal): I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to break in my tooth during treatment. I further understand the risks associated with root canal therapy may include: the inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth), Infection that may continue or reoccur, requiring further endodontic surgery or extraction, Fracture or breakage of the root or crown portion during or after treatment, Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved, Perforation of the tooth or root of the tooth during treatment, Damage to existing fillings, crowns or porcelain veneers. Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain). I understand that the tooth may be lost in spite of all efforts to save it and that a root canal is not a guarantee the tooth will be saved.

    Additional risks: _____
    Patient initials _____

11. Dentures and Partials: I understand that dentures will function differently than my natural teeth. Sore sports, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed after the extraction sites have healed completely. This is not included in the denture fee.

    Additional risks: _____
    Patient initials _____

12. Platelet Rich Fibrin: I understand that the use of Platelet Rich Fibrin (PRF) has been recommended by the Doctor to enhance postoperative healing. PRF is a component of my own blood, which contain growth factors that help stimulate soft tissue healing. I understand and consent to have several vials of my own blood drawn. My blood will be placed in a centrifuge to concentrate and activate the platelets. The blood used is my own. All blood drawing materials, needles, and all the centrifuge processing containers, are single use and are disposed in our medical waste container after each patient. Each PRF procedure uses its own sterile materials and supplies.

    Additional risks: _____
    Patient initials _____

13. Media and Social: I hereby give Smile Studio, and any and all employees and/or agents of Smile Studio, the right and permission to use and/or publish photographs of me or my child for art and promotional purposes including but not limited to, advertising, publicity, commercial or display of use. I also authorize my photos to be posted on social media, such as Facebook, Twitter, Instagram, etc., and the office's website page.

    Patient initials _____

I certify that I have read this form. I understand the potential risks, complications and side effects involved with any dental treatment or procedures and have decided to proceed with the procedures after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedures. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I hereby authorize any of the doctors, dental hygienists, or dental assistants to proceed with and perform the dental restorations and treatments indicated above and as explained to me.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Witness signature