Advanced Dental Care of Englewood
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INFORMED CONSENT

1 . TREATMENT TO BE PERFORMED

I UNDERSTAND THAT I AM HAVING THE FOLLOWING DENTAL TREATMENT PERFORMED BY ADRIJANA MIKSA, D.M.D., PLLC DENTIST: X-RAYS____, CLEANING____, FILLINGS____, BRIDGES____, CROWNS____, EXTRACTIONS____, IMPACTED TEETH REMOVAL____, ANESTHESIA____, ROOT CANALS____, OTHER ____

2. CHANGES IN TREATMENT PLAN

I UNDERSTAND THAT DURING THE TREATMENT IT MAY BE NECESSARY TO CHANGE OR ADD PROCEDURES BECAUSE OF CONDITIONS FOUND WHILE WORKING ON THE TEETH THAT WERE NOT DISCOVERED DURING EXAMINATION, SUCH AS ROOT CANAL THERAPY, FOLLOWING ROUTINE RESTORATIVE PROCEDURES. I GIVE MY PERMISSION TO THE DENTIST TO MAKE ALL CHANGES AND ADDITIONS AS NECESSARY AFTER I INITIALIZE THEM HERBY OR IN AN ADDITIONAL CONSENT.

(INITIALS_____)

3. DRUGS AND MEDICATIONS

I UNDERSTAND THAT ANTIBIOTICS, ANALGESICS AND OTHER MEDICATIONS ARE AN ESSENTIAL PART OF THE DENTAL TREATMENT, AND SOMETIMES CAN RESULT WITH UNPREDICTABLE ALLERGIC REACTION CAUSING REDNESS AND SWELLING OF TISSUES, PAIN, ITCHING, VOMITING, AND/OR EVEN ANAPHYLACTIC SHOCK (SEVERE ALLERGIC REACTION).

(INITIALS_____)

4. X-RAYS

I UNDERSTAND THAT X-RAYS IS AN ESSENTIAL PART OF MAKING A PROPER DIAGNOSIS AND DELIVERING PROPER DENTAL TREAMENT. THOUGH THERE IS A RADIATION IT DOES NOT AFFECT ME CONSIDERABLY THANKS TO A VERY SMALL DOSE; MY BODY BELOW THE NECK WILL NOT BE EXPOSED TO THE RADIATION AT ALL BECAUSE OF A SPECIAL PROTECTION APPLIED.

(INITIALS_____)

5. CLEANING

I UNDERSTAND THAT ANY CLEANING PROCEDURE OF MY TEETH SUCH AS A PROPHYLAXIS COULD REVEAL SOME HIDDEN CAVITIES AND/OR PROBLEMS WITH TEETH SURFACE THAT SHOULD BE TREATED AT MY CHOICE. THERE COULD BE AN UNUSUAL TASTE AND HYPERSENSITIVITY IN MY MOUTH FOR A WHILE.

(INITIALS_____)

6. REMOVAL OF TEETH

ALTERNATIVES TO THE REMOVAL HAVE BEEN EXPLAINED TO ME (ROOT CANAL THERAPY, CROWNS, PERIODONTAL SURGERY, ETC.) AND I AUTHORIZE THE DENTIST TO REMOVE THE FOLLOWING TEETH I UNDERSTAND THAT REMOVING TEETH DOES NOT ALWAYS REMOVE ALL INFECTION. IF PRESENT, IT MAY BE NECESSARY TO HAVE FURTHER TREATMENT. I UNDERSTAND THE RISK INVOLVED IN HAVING TEETH REMOVED, SOME OF WHICH ARE PAIN, SWELLING, SPREAD OF INFECTION, DRY SOCKET, LOSS OF FEELING IN MY TEETH, LIPS, TONGUE, AND SURROUNDING TISSUE THAT CAN LAST FOR INDEFINITE PERIOD OF TIME (DAYS OR MONTHS), OR FRACTURED JAW. I UNDERSTAND I MAY NEED FURTHER TREATMENT BY A SPECIALIST OR EVEN HOSPITALIZATION IF COMPLICATIONS ARISE DURING OR FOLLOWING TREATMENT.

(INITIALS_____)

7. CROWNS, BRIDGES, AND CAPS

I UNDERSTAND THAT SOMETIMES IT IS IMPOSSIBLE TO MATCH EXACTLY THE COLOR OF NATURAL TEETH WITH ARTIFICIAL TEETH. I FURTHER UNDERSTAND THAT I MAY BE WEARING TEMPORARY CROWNS (THE FEE IS NOT INCLUDED IN THE INITIAL CROWN OR BRIDGE FEE), WHICH MAY COME OFF EASILY AND THAT I MUST BE CAREFUL TO ENSURE THAT THEY ARE KEPT ON UNTIL THE PERMANENT CROWNS ARE DELIVERED. I REALIZE THE FINAL OPPORTUNITY TO MAKE ANY CHANGES IN MY NEW CROWNS, BRIDGE OR CAP WILL BE BEFORE CEMENTATION. (INITIALS_____)

8. DENTURES, COMPLETE AND PARTIAL

I REALIZE THAT BOTH COMPLETE AND PARTIAL DENTURES ARE ARTIFICIAL, CONSTRUCTED OR PLASTIC, METAL AND/OR PORCELAIN. PROBLEMS OF WEARING THESE DENTURES HAVE BEEN EXPLAINED TO ME, INCLUDING LOOSENESS, SORENESS, AND POSSIBLE BREAKAGE. I REALIZE THE FINAL OPPORTUNITY TO MAKE ANY CHANGES IN MY NEW DENTURES WILL BE THE "TEETH IN WAX" TRY-IN VISIT. I UNDERSTAND THAT MOST DENTURES REQUIRE RELINING APPROXIMATELY THREE TO TWELVE MONTHS AFTER INITIAL PLACEMENT. THE FEE FOR THIS PROCEDURE IN NOT INCLUDED IN THE INITIAL DENTURE FEE.

(INITIALS_____)

9. ENDODONTIC TREATMENT (ROOT CANALS)

I UNDERSTAND THERE IS NO GUARANTEE THAT ROOT CANAL TREATMENT WILL SAVE MY TOOTH, AND THAT COMPLICATIONS CAN OCCUR FROM THE TREATMENT. I REALIZE THAT OCCASIONALLY ADDITIONAL SURGICAL PROCEDURES FOLLOWING ROOT CANAL TREATMENT (APICOECTOMY) MAY BE NECESSARY.

(INITIALS_____)

10. PERIODONTAL LOSS (TISSUE BONE)

I UNDERSTAND THAT I HAVE A SERIOUS CONDITION, CAUSING GUM AND BONE INFLAMMATION OR LOSS, AND THAT IT CAN LEAD TO THE LOSS OF MY TEETH. ALTERNATIVE TREATMENT PLANS HAVE BEEN EXPLAINED TO ME, INCLUDING GUM SURGERY, REPLACEMENT AND/ OR EXTRACTIONS. I UNDERSTAND THAT UNDERTAKING ANY DENTAL PROCEDURES DOES NOT GUARANTEE A SUCCESS.

(INITIALS_____)

11. ANESTHESIA

I REALIZE THAT THERE WILL BE LOCAL ANESTHESIA ADMINISTERED DURING THIS TREATMENT. I HAVE BEEN INFORMED OF THE TYPE OF NATURE OF SUCH ANESTHESIA AND ALTERNATIVES TO IT AND I UNDERSTAND THE RISK IS NORMALLY INVOLVED IN THE ADMINISTRATION OF THIS ANESTHESIA INCLUDING A POSSIBILITY OF INFECTION, NUMBNESS OF LIPS, CHIN OR TONGUE AREA FOR AN UNDETERMINED PERIOD OF TIME.

(INITIALS_____)

I HAVE INFORMED THE DENTIST OF ANY SPECIAL INFORMATION REGARDING MY HEALTH, PHYSICAL OR MENTAL CONDITIONS, THAT MAY BE RELEVANT TO THE PERFORMANCE OF THE DENTAL TREATMENT. I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND NO RESULTS FROM THE DENTAL TREATMENT THAT I HAVE AUTHORIZED CAN BE GUARANTEED. ALSO

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I UNDERSTAND THAT I MAY REFUSE TO CONSENT TO ANY AND ALL TREATMENTS OR PROCEDURES SPECIFIED ABOVE. I HAVE READ, UNDERSTOOD AND INITIALIZED THIS INFORMED CONSENT AND I HEREBY GIVE MY FREE AND VOLUNTARY CONSENT TO ABOVE LISTED PROCEDURES AND ALL THE DENTAL TREATMENT INCLUDING ANY CHANGES (SEE #2) THAT ARE DEEMED NECESSARY OR ADVISABLE BY THE DENTIST DURING THE COURSE OF THIS TREATMENT.

SIGNATURES

PATIENT: ____ **DATE ________________**

LEGAL GUARD: ____ **DATE ________________**

DENTIST: ____ **DATE ________________**

WITNESS____ **DATE ________________**