Patient Name:____

CONFIDENTIAL REGISTRATION CONSENT FORM

- I understand that I am having any or all of the following treatment done: x-rays, examination, dental cleaning, fillings, inlays/onlays, crowns, bridges, extractions, root canals, dentures, periodontal (gum) treatment, bleaching (tooth whitening), local anesthesia, other _____________________________________.
- I have been informed and understand that antibodies, analgesics and medication can cause allergic reactions, including redness and swelling of tissues, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) and they can cause pain, thrombophlebitis (inflammation of vein) from intravenous and intramuscular injections, injury to and stiffening of the neck and facial muscles. They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from any medication. Failure to take the medication prescribed to me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to the effective treatment of my condition.
- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth (which were not discovered during examination), the most common being root canal therapy following routine restorative procedures. I give permission to the treating dentist to make any/all changes as necessary.
- Alternatives to extractions of teeth have been explained to me (root canal, crowns, and periodontal treatment, etc.) and I authorize the treating dentist to remove teeth as necessary. I understand removal of teeth does not always eliminate all infection and it may be necessary to have further treatment. I understand the risks involved in having extractions, some of which may be pain, swelling, spread of infection, dry socket, excessive bleeding, fractured jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
- For crowns, bridges, veneers, inlays/onlays, and bondings, I understand that it is sometimes not possible to exactly match the color of my natural teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize that the final opportunity to make changes in my new crown, bridge, inlay/onlay (including shape, fit, size and color) will be before cementation. It has been explained to me that in very few cases, cosmetic or other dental procedures may result in the need for future root canal therapy, which cannot always be predicted or anticipated. In such instances my treating dentist may decide to perform the root canal or refer me to an endodontist. Either way, I am responsible for the cost of such a procedure. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily oral hygiene.
- For dentures (complete or partial), I realize that these prostheses are constructed of plastic, metal, and/or porcelain. Problems associated with these prostheses have been explained to me including looseness, soreness, changes in my speech, and breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, and color) will be the “try-in” visit. At that stage, the teeth are in wax and can be changed prior to when the teeth are permanent in acrylic. I understand that most dentures require relining approximately 3-12 months after their initial placement. The cost for this procedure is not included in the initial denture fee.
- For root canal treatments, I realize that there is no guarantee that the procedure will save my tooth, that complications can occur from this treatment, and that occasionally, metal objects are cemented in the tooth or extended through the root, which does not affect the success of the treatment. I understand that occasionally, additional surgical procedures (apicoectomy and/or retrofill) may be necessary following root canal therapy, and that I would be responsible for the cost of these procedures.
- I have been informed about the risks and consequences of periodontal (gum) disease if left untreated, including infection, pain, looseness and loss of teeth, possible cardiovascular complications, and bad breath (Halitosis). Alternatively periodontal treatment plans have been presented to me and I understand there is no guarantee that these treatments will save my teeth.

I understand that dentistry is not an exact science, and therefore practitioners cannot 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 is individually responsible for the dental care rendered to me. (*Please sign below*):

Signature of Patient (or parent/guardian if patient is a minor)______________________________ **Date**______________

I have read and signed the Acknowledgement of Notice of Privacy Practices on File. (*Please sign below*):

Signature of Patient (or parent/guardian if patient is a minor)______________________________ **Date**______________

I have received a copy of the Dental Materials Fact Sheet as required by law. (*Please sign below if applicable*):

Signature of Patient (or parent/guardian if patient is a minor)______________________________ **Date**______________

43195 Mission Blvd Suite B-4, Fremont, CA 94539 | (510) 651 – 8479 | office@dentalcarefremont.com