PROCEDURE POLICIES

PATIENT NAME_____ ACCOUNT #_____

1. **WORK TO BE DONE**
   I UNDERSTAND THAT I AM HAVING THE FOLLOWING WORK DONE: FILLING____CROWN____DENTURE____PARTIAL DENTURE____ X-RAYS____EXAM____ INITIALS____

2. **DRUGS AND MEDICATIONS**
   I UNDERSTAND THAT ANTIBIOTICS AND ANALGESICS AND OTHER MEDICATION CAN CAUSE ALLERGIC REACTIONS CAUSING REDNESS AND SWELLING OR TISSUE PAIN,ITCHING,VOMITING AND/OR ANAPHYLACTIC SHOCK. INITIALS____

3. **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 DISCOVERED DURING EXAMINATION. FOR EXAMPLE: ROOT CANAL THERAPY FOLLOWING ROUTINE RESTORATIVE PROCEDURES. I GIVE MY PERMISSION TO THE DENTIST TO MAKE ANY CHANGES/ ADDITIONS AS NECESSARY. INITIALS_____

4. **CROWNS (CAPS) AND BRIDGES**
   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 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 CHANGES IN MY NEW CROWNS OR BRIDGE (INCLUDING SHAPE,FIT,COLOR AND SIZE) WILL BE BEFORE CEMENTATION. IT IS ALSO MY RESPONSIBILITY TO RETURN FOR PERMANENT CEMENTATION WITHIN 30 DAYS OF TOOTH PREPARATION DATE. EXCESSIVE DELAY MAY ALLOW FOR TOOTH MOVEMENT. THIS MAY NECESSITATE A REMAKE OF THE CROWN OR BRIDGE WHICH I UNDERSTAND THAT ADDITIONAL CHARGES WILL BE ADDED FOR REMAKES DUE TO MY DELAYING THE CEMENTATION OF PERMANENT CROWN OR BRIDGE. NON-PRECIOUS CROWNS CONTAIN NICKLE,CHROME AND BERYLLIUM IN SOME CASES CAN RESULT IN DERMATITIS AND/OR OTHER COMPLICATIONS. PERSONS WITH KNOWN SENSITIVITY SHOULD AVOID ITS USE ,PLACING NON-PRECIOUS AND PRECIAOUS METALS TOGETHER CAN CAUSE GALLIVANIC SHOCK. INITIALS_____

5. PERIODONTAL DISEASE (TISSUE AND BONE LOSS)

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,REPLACEMENTS AND/ OR EXTRACTIONS. I UNDERSTAND THAT UNDERTAKING ANY DENTAL PROCEDURES MAY HAVE A FUTURE ADVERSE EFFECT ON MY PERIODONTAL CONDITION. INITIALS_____

5. COMPOSITE RESTORATIONS (FILLINGS)

I UNDERSTAND THAT CARE MUST BE EXERCISED IN 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 SIGNIFICANT SENSITIVITY IS A COMMON AFTER EFFECT OF A NEWLY PLACED FILLING. NOTIEC:SILVER AMALGAM FILLINGS CONTAIN A MIXTURE OF MERCURY,SILVER,COPPER,ZINC AND TIN. MERCURY IS A TOXIC METAL AND CAN CAUSE ADVERSE HEALTH CONDITIONS AN ALTERNATIVE TO AMALGAM FILLINGS ARE LIGHT CURED COMPOSITE FILLINGS ON POSTERIOR (BACK) TEETH INITIALS____

6. DENTURE OR PARTIAL DENTURES

I UNDERSTAND THE WEARING OF DENTURES IS DIFFICULT SORE SPOTS, ALTERED SPEECH AND DIFFICULTLY IN CHEWING ARE COMMON PROBLEMS. IMMEDIATE PLACEMENT OF DENTURES AFTER EXTRACTIONS MAY BE PAINFUL. IMMEDIATE DENTURES MAY REQUIRE CONSIDERABLE ADJUSTING AND SEVERAL RELINES TO ENSURE PROPER FIT. A PERMANENT RELINE WILL BE NEEDED LATER THIS RELINE IS NOT INCLUDED IN THE PRICE OF ORIGINAL DENTURE. I UNDERSTAND IT IS MY RESPONSIBILITY TO RETURN FOR DELIVERY OF THE DENTURE/PARTIAL AND THAT FAILURE TO KEEP ANY APPOINTMENTS MAY RESULT IN POORLY FITTED DENTURES. IF A REMAKE IS REQUIRED DUE TO MY DELAYS OF MORE THAN 30 DAYS THERE WILL BE ADDITIONAL CHARGES.

INITIALS_____

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THEREFORE A RELIABLE PRACTIONER CANNOT PROPERLY 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 PRACTIONER AND IS RESPONSIBLE FOR THE DENTAL CARE RENDERED TO ME. I UNDERSTAND THAT NO OTHER DENTIST NOR DENTAL GROUP IS RESPONSIBLE FOR MY DENTAL TREATMENT.

I HEREBY AUTHORIZE ANY OF THE DOCTORS OF THE DENTAL GROUP TO PROCEED WITH AND PERFORM THE DENTAL TREATMENT AS EXPLAINED TO ME. I UNDERSTAND THAT THIS IS ONLY AN ESTIMATE AND SUBJECT TO MODIFICATION DEPENDING ON UNFORESEEN OR DIAGNOSABLE CIRCUMSTANCE THAT MAY ARISE DURING THE COURSE OF TREATMENT. I UNDERSTAND THAT REGARDLESS OF ANY DENTAL INSURANCE COVERAGE I MAY HAVE I AM RESPONSIBLE FOR PAYMENT OF DENTAL FEES. I AGREE TO PAY ANY ATTORNEY FEES, COLLECTION FEES OR COURT COST THAT MAY BE INCURRED. I UNDERSTAND THAT ANY CO-PAYMENTS INCURRED FOR SERVICES RENDERED TODAY WILL BE DUE AND PAYABLE BEFORE I LEAVE THE OFFICE. I HAVE READ UNDERSTOOD AND AGREE TO ALL OF THE ABOVE. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AND EFFECTIVE AS THE ORIGINAL COPY HEREAFTER. I AM OF LEGAL AGE AND LEGALLY COMPETENT TO MAKE THIS ASSIGNMENT. THIS CONSENT FORM SHALL SERVE AS A LEGAL DOCUMENT.

ANY TRANSFERRING OR DUPLICATION OF X-RAYS OR DIAGNOSTICS WILL BE $20.00 AND UP. FEE CHARGED PER OUR DISCRETION AND PAYABLE BEFORE ANY RECORDS CAN BE RELEASED PER "HIPPA" FORM SIGNED

SIGNATURE:_____ DATE:_____
PATIENT,PARENT,LEGAL GUARDIAN

DOCTOR:_____ WITNESS:_____