Fresh Family DENTAL

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Informed Consent for Initial Examination, X-Rays & Cleaning

Patients Name: _____ **Phone Number:** _____ **DOB:** _____

Email Address: _____

1. Dental Office Informed Consent- Its important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may with your agreement perform. We want to involve you in all decisions concerning incisive procedure you may need. We take informed consent very seriously in our office. Therefore, we only want you to initial form when you understand that there is a risk associated with dental procedures, and all your questions have been answered. Dental treatment and procedures are not to be take for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment. There are no guarantees that the results will be as planned and to everyone's satisfactions. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like 'fillings" can lead to major complications that cannot be foreseen. For example, "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatment. The above examples are only samples of possible complications with dental treatment and are not limits to these. In general , complications include but are not limited to pain, swelling, bleeding, infections, other nerve problems. I have read & understood and give my consent to dental treatment. **(Initials_____)**

2. **Examinations and x-rays-** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that I have to get treatment done as detailed in the treatment plan based on diagnosis by Dr. Patel **(Initials_____)**

3. Dental Photography- I authorize to take photography's, and/or videos of my face, jaws and teeth, before during and after treatment. I consent to allow the photographs to be used for the follow:
*Dental Records * Dental Research* Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books *Marketing material, including websites, printed materials, patient education.
I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of my photographs**.** **(Initials _____)**

4. **Drugs/ Medications**- I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and / or anaphylactic shock (server allergic reaction.) they may cause drowsiness, 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 the effects of the anesthetic, medication and drugs that maybe have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risk of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompany risk, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking. I have informed Dr. Patel of any known drug allergies **(Initials_____)**

5. **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, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Patel to make changes and additions as necessary. **(Initials_____)**

6. **Tempro- Mandibular Joint Dysfunction (TMJD)** - I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMDJ associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. **(Initials_____)**

7. **Dental Prophylaxis (Cleaning)**- I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums and is limited to the removal of plaque and extremely light tarter & stains from tooth structures in the absence of periodontal (gum) disease. This treatment prevents gingivitis & gum disease**.** **(Initials _____)**

Signature of patient, parent, guardian: _____Date: _____

Doctors Signature: _____ Date: _____