# ***Bright Smiles Dentistry***

## General Dentistry Informed Consent

Patient:_____ Date of Birth:_____

I understand that my treatment plan possibly includes the following

●Fillings ● X-rays ● Crowns ● Bridges ● Root Canals ● Dentures ● Cleanings

I give my permission and consent to have my dental provider diagnose and treat dental conditions discovered during examination. I also understand that procedures such as X-rays will aid my provider in diagnosing these conditions and by declining this or any other procedure it may put my dental health at risk.

1. **MEDICATIONS**: I understand that in providing treatment the dentist may administer medications in the form of antibiotics, analgesics and other medications which can cause allergic reactions as well as a number of adverse effects including addiction.

2. **ANESTHESIA**: may also be administered which can have a number of side effects including but not limited to: tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke and heart attack.

3. **CHANGES IN TREATMENT:** 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. I understand any changes will be discussed with me at the time of their discovery.

4. **PERIODONTAL THERAPY**: may be performed to reduce or eliminate periodontal disease which causes gum inflammation and pocketing around the teeth. My dentist and/or hygienist may recommend periodontal therapy to improve the overall health of my gums and teeth. I understand the benefit of this therapy is partially dependent on my compliance with my dentist and/or hygienist.

5. **CROWNS, BRIDGES, DENTURES**: I understand artificial teeth such as Crowns/Bridges/Dentures can provide risks, possible unsuccessful results and/or failure associated with, but not limited to the following: reduction of tooth structure, sensitivity of teeth, possible root canal breakage, uncomfortable or strange feeling, esthetics or appearance of longevity of crowns, bridges, etc.

6. **POSTS AND RETENTION PINS**: I understand the placement of Posts and/or retention pins are sometimes necessary when there is inadequate tooth structure remaining to support restoration of a particular tooth or teeth. I accept the risks of this treatment including but not limited to: root canal therapy, crowns or root fracture, perforation, numbness, soreness and sensitivity.

7. **FILLINGS**: I understand that during the placement or replacement of any fillings it is possible to cause trauma to underlying pulp tissues. Trauma may feel like extreme sensitivity or possible abscess and root canal treatment or extraction may be required. Over a period of time Composite (white) fillings, because of mouth fluids and other factors, may cause the shade of the filling to change or be dislodged or fractured. Likewise, Amalgam (silver) fillings are subject to fracture while chewings, especially during the first 24 hours of placement. I understand either type of filling may be used depending on the prognosis of each tooth and the dentist's recommendation.

**I understand dentistry is not an exact science and therefore, reputable practitioners 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.**

Signature of Patient _____ Date:_____

Signature of Dentist _____ Date:_____