

Consent for Dental Treatment

Patient Name: _____ Date: _____

I hereby consent/refuse to the following described dental procedures upon me by or under the direction of Dr. Koons, his associates and assistants.

In the event that Dr. Koons becomes unavailable, I authorize him to select a replacement to accomplish the agreed upon procedures without delay.

I acknowledge that the following information has been provided to me.

Nature of my dental illness: Periodontal disease, abscessed tooth, cracked broken tooth, teeth with failing restorations, unrestorable teeth, decayed teeth, missing teeth, posterior (back) bite collapse, bite problems.

The purpose of the following procedure is to correct, restore or improve the above conditions.

Treatments: I understand that I am having the following dental treatment done: (please read and initial the items checked below)

1. Anesthesia and medications

I consent to administrations of local anesthesia and other drugs deemed necessary in my case and understand the risks of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/or permanent nerve damage or other unforeseeable complications which may result from the administration of my drug or anesthetic. **Sedation--** Possible side effects of oral sedation include but are not limited to: temporary amnesia, difficulty in walking, confusion, lethargy, and respiratory depression. Rarely, the side effects may include an allergic reaction or mild nausea. For a very small number of persons, the drug may not be effective in producing sedation.

2. Periodontal therapy (Periodontics)

I understand that I have a serious condition causing gum and bone infection or loss that can lead to the loss of my teeth. Alternative treatment has been explained to me including gum surgery, tooth replacements and/or extractions. I understand that not undertaking any dental procedure may have a future adverse effect on my periodontal condition.

3. Root Canals (Endodontics) and Posts

I realize there is no guarantee that root canal therapy and posts will save my tooth, and that complications can occur from the treatment. Complications can include breakage of metal objects in the tooth and over extension of cement or filling materials outside the root tip that may result in permanent nerve damage. I understand that further, although rare, perforations (going out the side of the tooth) can occur. I am also aware that, after root canal therapy a crown or onlay will need to be placed on the tooth.

4. Tooth and tissue removal (Oral surgery)

Alternative to removal have been explained to (root canals, crowns, and periodontal surgery, etc) and I authorize Dr. Koons, his associates and assistants to remove the following teeth and any other necessary for reasons described in the first paragraph above (nature of my dental illness). I understand that removing teeth does not always remove all the infection and if infection remains it may be necessary to have further treatment. I understand the risks involved in removing my tooth/teeth some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last an indefinite amount of time and/or a fractured jaw. I understand I may need further treatment by a specialist or even hospitalization for complications, which may arise during, or following treatment, the cost of which is my responsibility. I understand that tooth replacement will be necessary soon after the removal of my teeth. (Except wisdom teeth (3rd molars).

5. Tooth Colored Fillings (composites)

I understand that my teeth need new or replacement fillings. Certain side effects can include hot, cold, and/or biting sensitivity (pressure). With larger cavities, root canals and/or crowns may be necessary to stabilize my tooth/teeth. (Occasionally a "high spot" in your bite may develop after the numbness has worn off. If this occurs please contact our office immediately for an adjustment of the " high spots"). I understand it is sometimes not possible to match the color of natural teeth exactly with artificial filling materials.

6. Tooth Colored/Gold Crowns and Bridges

I understand that I may be wearing temporary crowns or bridges, which may come off easily, and that I must be careful to ensure they are kept in place until the custom crown or bridges are placed. I further understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand the final opportunity to make changes in my new crowns/bridges color, shape, fit or size before cementation. I realize that some crowns and bridges are used to treat decay and fracture and therefore may require root canal therapy during or after treatment if symptoms arise.

7. Partial and Complete Dentures

I realize that complete or partial dentures are artificial and are constructed of plastic, metal and/or porcelain. The problems in wearing these appliances have been explained to me, include looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including fit, size, placement, and color) will be the "Teeth in Wax" visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee. I also understand that all adjustments are included for one month following the placement of the denture. Any future adjustment will have a fee.

8. Bite Balancing

I understand that bite balancing is done to help reduce wear and tear on my teeth and jaw joints. This treatment involves two steps. The first step is to determine what treatment would be required to get my bite balanced. The second step is the actual treatment. I understand that there is a separate fee for each step and the fee for the second step cannot be determined until the first step is completed. Treatment almost always involves reshaping the back teeth by drilling some of the tooth surface away. No guarantees can be made as to how much improvement will result in either the comfort of the jaw joint or reduction in grinding activities. I understand that bite balancing is almost always followed up with a grinding guard that is to be worn at night and that there is a separate fee for the guard.

8. Financial Responsibility

I understand that Dr. Koons and his staff feel that dental treatment is an excellent investment in an individual's medical and psychological well- being and financial considerations should not be an obstacle to obtaining this important health service. In their efforts to make their services more affordable for the patients, they have several forms of payment. Regardless of method of payment I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers compensation and the like. I also agree to pay for services when they are rendered unless other arrangements have been made with the financial coordinator. I understand that financial changes will be added to my account for delinquent payments at the rate of one and one-half percent per month on the total balance. I further agree to pay for attorney's fees and collection costs in the event I fail to pay or my insurance fails to pay my account in full within 90+ days of receipt of services.

I further consent to the admission of observers into the procedure for the purpose of medical education or science. I further agree that photographs may be taken of me during the procedure and that the photographs and a narrative of my case may be used for medical education of science, including publication in professional journals and medical books. I consent to the performance of operations and procedures in addition to or different from those above contemplated which Dr. Koons or his associates and assistants consider therapeutically necessary even though this procedure may be an emergency. I understand that the extension of this procedure may include risks not previously discussed but, nevertheless, grant to Dr. Koons, his associates and assistants, the authority to proceed with such additional procedures. I further consent to the disposal of tissue or parts removed at the time of the operation. I realize that it is mandatory that I give as accurate and complete medical and personal history as possible and that I have done so. I further agree to follow any and all instructions as directed and permit prescribed diagnostic procedures. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have requested authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with Dr. Koons, his associates or assistants and that I understand the information provided.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____