Justice Family Dentistry
INFORMED CONSENT FOR SERVICES

WORK TO BE DONE
I understand that I may be having the following work done: Fillings___, Crowns/Onlays/Inlays___, Extractions___, Impacted teeth removed___, Root canals treated___, Dentures___, X-rays___, Other_____ (Initials_____)

DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and other medications can cause allergic reactions: redness, swelling, pain, itching, and/or anaphylactic shock.
(Initials_____)

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 the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make
any/all changes and additions necessary. (Initials_____)

CROWNS/ ONLAYS/ INLAYS, BRIDGES
I understand that sometimes it's not possible to match the color of artificial teeth exactly to the natural teeth. I further understand that I may be wearing temporary crowns/fillings that may come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize that the final opportunity to make changes to my restoration (including shape, size, fit and color) will be before cementation. It is also my responsibility to
return for permanent cementation within 20 days from the preparation date. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to me delaying permanent cementation. (Initials_____)

ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth, which does not necessarily, affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments; stresses vented in their manufacture can cause them to separate or break during use. I understand that sometimes additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all the efforts to save it. Root canalled teeth must be covered by crowns or bridges. (Initials_____)

PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition, causing gum inflammation, bone loss and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

PERIODONTAL CLEANING/ SCALING
I understand that most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, breaking of fillings. Reactions to fluoride treatment may be nausea or vomiting. (Initials_____)

FILLINGS
I understand that the most common complications are pain, sensitivity to temperature, fracture of tooth, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, reactions to drugs and/or anesthesia. (Initials_____)

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment with I have requested and authorized. I hereby authorize any of the doctors at this facility and dental auxiliaries to proceed with and perform the dental procedures and treatments as had been explained to me. I understand this is only an estimate and subject to modification depending on foreseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

PATIENT _____ **DOCTOR** _____

Signature of patient _____ **Signature of doctor** _____

DATE _____ **WITNESS** _____