GALLERIA DENTAL
FAMILY • COSMETIC • ORTHODONTICS
IMPLANT & GENERAL DENTISTRY

Galleria Dental: General Dentistry Informed Consent

- **Work to be Done**

I understand that I may be having the following work done: Fillings, Extractions, X-rays, Root Canals, Dentures, Exam, Cleaning, etc.

Initials_____

- **Drugs & Medication**

I understand that antibiotics may interfere with the effectiveness of contraceptives. Antibiotics, as well as analgesics and other medications cause allergic reactions causing redness and swelling of tissues; Vomiting 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 the conditions found while working on the teeth that were not previously discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Initials_____

- **Removal Teeth**

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the teeth and any other necessary for reasons in paragraph#3. I understand removing teeth does not always remove infection, if present, it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some which are pain, swelling, and the spread of infection, dry socket and loss feeling in my teeth. MPS, swelling and/o prickling of tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment if complications arise during or following treatment if complications arise during or following treatment, the cost of which is my responsibility.

Initials_____

- **Dentures**

I understand that the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after instructions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be necessary later. This is not included in the denture fee. I understand that is it is my responsibility to return for delivery of dentures, I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required do to my delays of more than 30 days, there will be additional charges. The denture try-in appointment is designed to allow the patient to approve the cosmetic aspects of the denture. Please look closely at the size, shape, color, fullness, and arrangement of the teeth. I understand that any changes made after the denture is complete will result in the charge of a lab fee. **Initials**_____

- **Endodontic Treatment (Root Canal)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatments, and that occasionally the canal filling material 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 and stresses created during their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost n spite of all efforts to save it.

Initials_____

- **Periodontal Loss (Tissue and Bone)**

I understand that sometimes it is not possible to match the color of my 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 final crown, bridge, or cap(including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crow,, bridge, cap. I understand there will be additional charges for remarks due to my delaying permanent cementation.

Initials_____

I understand that there has been no guarantee or assurance made by anyone in regards to my dental treatments; and also give my authorization for dental treatment. I also acknowledge that I am responsible for payment of all dental fees regardless of any insurance coverage.

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Patient Name (Print) Date

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Patients Signature - Date