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Informed Consent

I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be initiated/completed and have read and been given the opportunity to ask questions that I may have regarding the procedure. I also understand the possible risks, alternatives, and benefits of the procedure(s).

INITIALS:_____

1) **X-rays & Examination**: In order to receive a comprehensive examination, diagnosis, and treatment plan, I consent to an examination, X-rays, periodontal charting, models, photographs, and any diagnostic testing needed for the development of my treatment plan. I understand that while x-rays are taken on my teeth, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant, I am required to have a medical release from my physician prior to x-rays and treatment.

INITIALS:_____

2) **Changes in Treatment Plan**: I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to Dr. Peterson, Dr. Hendricks and/or Dr. Walker to make any and all changes and additions as necessary.

INITIALS:_____

3) **Drugs, Medication, and Sedation**: I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed Dr. Peterson and/or Dr. Hendricks of any known allergies. These medications, drugs and oral sedatives 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 oral sedatives that may have been given to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. For Women: I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills) therefore; caution must be exercised to utilize other methods of contraception during this time. If I am taking a type of drug called bisphosphonates (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa®, and Bonefos®) used to treat osteoporosis and similar bone density diseases/cancers, I will inform Dr. Peterson and Dr. Hendricks as I may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatment may increase that risk. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell Dr. Peterson and Dr. Hendricks of any changes in my health status and all of the medications I am currently taking and the dosages of each medication, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications or changes in my health status, prior to starting dental work may have unforeseen negative consequences for me.

INITIALS:_____

4) **Temporomandibular Joint Dysfunction (TMD)**: 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 wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

INITIALS:_____

5) **Dental Prophylaxis (Cleaning)**: I understand the treatment is preventative in nature and is intended for patients with healthy gums. Dental Prophylaxis (cleaning) involves removal of plaque and calculus above and below the gum line and will not address infections below the gum line if a patient has periodontal (gum) disease. I understand that some bleeding may occur.

INITIALS:_____

6) **Periodontal Treatment**: I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand that bleeding may occur and could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and I will contact the dental office. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

INITIALS:_____

7) **Fillings**: I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. I understand that dental treatment,

present or past, may stress the nerve of the tooth causing sensitivity. Although the bite will be carefully checked, numbness can cause the patient to bite incorrectly. I understand that after the numbness wears off, the filling may need to be adjusted. Sensitivity is common after a filling is placed. If the sensitivity is severe and continuous, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being placed.

INITIALS:_____

8) **CEREC® Restorations, Onlays, Crowns, Bridges and Veneers**: I understand that care must be exercised in chewing on any new dental restoration (i.e. CEREC, onlay, crown, bridge, veneer) during the first 24 hours to avoid breakage. I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. I understand that dental treatment, present or past, may stress the nerve of the tooth causing sensitivity. Although the bite will be carefully checked, numbness can cause the patient to bite incorrectly. I understand that after the numbness wears off, the dental restoration may need to be adjusted. Sensitivity is common after a CEREC, Onlay, Crown, Bridge or Veneer is placed. If the sensitivity is severe and continuous, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the CEREC, Onlay, Crown, Bridge or Veneer being placed. I understand that sometimes it is not possible to match the color of 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 that the final opportunity to make changes to my new crown, bridge, or veneer (including the shape, fit, size and color) will be before cementation. It has been explained to me that CEREC, Onlay, Crown, Bridge, and Veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. If a temporary crown is placed, it is also my responsibility to return for permanent cementation within 25 days after tooth preparation. Excessive delays may allow for decay, tooth movement, accumulation of bacteria, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

INITIALS:_____

9) **Extractions**: Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc) I understand that removing teeth does not always remove the infection, if present, and may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, fractured jaw, and loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time. I understand that bleeding could last for several hours. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

INITIALS:_____

10) **Endodontic Treatment (Root Canal)**: I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally canal material may extend through the root tip, which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. If a crown is not currently present on the tooth requiring a root canal, in many cases a crown will be required in the future for an additional fee. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy) and I may be referred to an Endodontist (root canal specialist). I understand that the tooth may be lost in spite of all efforts to save it.

INITIALS:_____

11) **Implants and Implant Crowns**: I understand that nothing in dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations, which can affect the esthetics of the final restoration (i.e. implant crown, implant bridge or implant retained denture/partial). I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively, which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implants to have regular yearly examinations, x-rays of implants and cleanings. I agree to assume the responsibility to make periodic exam/cleaning appointments.

INITIALS:_____

12) **Dentures, Partials or Stayplates**: I understand that wearing dentures, partials or stayplates is difficult. I realize that dentures, partials and stayplates are removable artificial substitutes for teeth constructed of plastic, metal and/or porcelain. The problems of wearing those appliances include looseness, sore spots, altered speech, difficulty chewing, and possible breakage. I realize that during fabrication of my new denture/partial, the final opportunity to make changes in my new denture/partial (including tooth shape, size, shade and tooth placement) will be in the "teeth in wax" try-in visit. If I change my mind about the esthetics of the appliance after the denture/partial is processed and delivered, I am aware that an entirely new denture/partial will have to be made and I will be responsible for the cost of the new appliance. Immediate dentures (placement of dentures immediately after extractions) and stayplates (temporary partials) may not have a "try in appointment", so in some cases, patients will not be able to see the final result until the appliance is delivered. I am aware that if I am receiving an immediate denture or a stayplate, the teeth may not be the correct shade, shape, or in ideal position. Furthermore, I am aware that an additional removable appliance will be needed in future if I receive an immediate denture or stayplate. Any removable appliance can be uncomfortable/painful at first. Immediate dentures may require several adjustments and relines. A permanent reline of an immediate denture will be needed in the future for an additional fee. I understand that most dentures require relining. The cost for a permanent laboratory reline is not included in the initial denture fee. I understand that once I start the process of having dentures fabricated, it is important that I keep my scheduled appointments. Failure to keep appointments, after impressions are taken may result in poorly fitting dentures, partials, or stayplates. If a remake is required due to my delay, there will be additional changes.

INITIALS:_____

13) **Bleaching (Teeth Whitening)**: Teeth whitening is a procedure completed either in-office or with take-home trays. The degree of whitening varies with the individual. Some teeth respond better to the whitening process than others. I am aware that significant lightening of the shade of teeth can be achieved in a majority of cases, but the results cannot be guaranteed. When done properly, whitening will not harm your teeth or gums. Like any other treatment, it has some inherent risks and limitations. These are seldom serious enough to discourage you from having your teeth whitened, but should be considered when deciding to have treatment. Potential problems experienced with bleaching include: tooth sensitivity, gum irritation, and relapse. I understand that if I already have sensitive teeth prior to bleaching I will tell Dr. Peterson, Dr. Hendricks, and Dr Walker before I bleach my teeth. There are products that can be prescribed which can make the bleaching process more comfortable. If you do experience sensitivity during or after bleaching, usually the sensitivity will resolve itself in 1-2 days, if not sooner. I also understand that the bleach my cause "white spots" and/or mild redness on my gums. I am aware that I may also experience a burning/swelling of the lips. Generally these types of irritations will resolve themselves in a couple of days. Certain foods and drinks can re-stain your teeth quickly following bleaching, causing teeth to relapse to their initial shade. For the first 48 hours, I will avoid foods/beverages, which stain "a white shirt" like: red wine, dark sodas,

coffee, tea, ketchup, mustard, berries, and tobacco products. I realize that restorations on teeth, like tooth colored fillings, CEREC restorations, crowns, veneers and bridges will not lighten. I am aware that having my teeth cleaned, in order to remove any food particles, calculus or stains from teeth prior to bleaching will provide a better result. Pregnant women are advised to have a medical release from their physician before starting bleaching.

INITIALS:_____

I understand that dentistry is not an exact science: therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized. I hereby authorize Dr. Peterson, Dr. Hendricks, Dr Walker and staff members to proceed with and perform dental treatment as explained to me. I understand that if I am given post-operative instructions, it is my responsibility to follow those instructions.

My signature below indicates that I have read and understand the above information and I am willing to comply with the foregoing, and that I am the patient, the parent or legal guardian of the patient with the authority to give consent, or that I am duly authorized by the patient as the patient's legal agent to execute the above and accept its terms.

_____ _____

Patient's Name (print) **Date**

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Signature of Patient/Parent or Legal Guardian

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***If Applicable - Name of Parent/Legal Guardian (print)**