CONSENT FOR ROUTINE DENTAL TREATMENT

Patient name: _____ Date:_____

I hereby authorize the Doctors of St. Albans Dental and any Associates to perform the following routine dental procedures. I understand that prior to the initiation of any treatment I will have the opportunity to review the proposed treatment, risks, benefits, and alternatives, as well as my financial responsibility.

I understand that I may be having the following work done but not limited to: Cleanings, Fillings, X-Rays, Exams, Periodontal treatment, Crowns/Inlays/Onlays, Extractions, Root Canals, Dentures/Partials, Tooth Whitening, Orthodontics (Invisalign), Surgery, Oral Sedation, or Implants.

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 permission to the treating doctor and associates to make any changes and additions necessary.

DIAGNOSIS - I understand that diagnostic procedures can involve several appointments/ multiple radiographic images and in complex cases an additional specialist examination may be required to develop a comprehensive treatment plan.

DRUGS AND MEDICATIONS - I understand that antibiotics, analgesics and/ or other medications can cause allergic reactions, redness, swelling, pain, itching, and/or anaphylactic shock. It is my responsibility to inform my treating practitioner about any possible allergies I may have.

LOCAL ANESTHESIA - I understand that local anesthesia is recommended for most of the procedures performed and its benefits far outweigh the potential risks, however I am aware that it can result in allergic reaction and life threatening anaphylactic shock. Furthermore, it can result in permanent damage to the nerve, partial or complete permanent numbness lasting several days to months, bruising or formation of hematoma.

PREVENTATIVE TREATMENT - I understand that my dentist may recommend alternative approaches for optimization of my dental / overall health, including but not limited to nutritional counseling/ tobacco counseling/ oral hygiene instructions/ fluoride treatment.

WHITENING TREATMENT - There may be sensitivity associated with the whitening procedures done in the office (zoom) and at home (trays, strips, pen). It is a common consequence of whitening. Patient is advised to take analgesics and treat the area with topical fluoride until sensitivity subsides.

PERIODONTAL CLEANING/ SCALING AND ROOT PLANING - I understand that the most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, ulceration (infection), tooth fracture, breaking of fillings, dislodging of crowns or veneers. Reaction to fluoride treatment may cause nausea or vomiting.

PERIODONTAL LOSS (TISSUE AND BONE) - I understand that I may 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, bone grafts,, extractions, laser treatment and bacterial irrigation. Any dental procedures may have future adverse effects on my periodontal condition.

RESTORATIVE TREATMENT - 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/ anesthesia. I understand that sometimes existing caries may cause inflammation of the nerve and subsequently filling restorations may have to be further treated by a root canal therapy due to initial underlined inflammation of the nerve.

Also I understand that once the tooth is restored with a filling material it is never going to feel the same as natural tooth. It may be sore, temperature sensitive or pressure sensitive for several weeks. The position of my teeth is dynamic condition therefore bite adjustments may be required following the restorations.

CROWNS/ INLAYS/ ONLAYS/ BRIDGES - I understand that sometimes it is not possible to match the color of the artificial teeth exactly to natural teeth. I further understand that I may be wearing temporary crowns/ fillings that may come off easily and 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 30 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 an additional charge for remakes due to me delaying permanent cementation.

I also understand that I may require root canal therapy after routine crown/ inlay/ onlay/ bridge preparation It will be determined by my healthcare provider at the time of presenting symptoms if further treatment with root canal therapy is required.

DENTURES AND PARTIALS - I understand that wearing dentures or partials may be difficult. Sore spots, altered speech and difficulty eating are common problems. Immediate dentures

(placed right after surgery/ extractions) may be painful and may require considerable adjustments and several relines. Regular follow up is necessary to maintain soft tissue health and optimized healing. A permanent reline will be needed later. This is not included in the denture fee. I understand that this is my responsibility to return for delivery of dentures and follow up appointments. I understand that failure to keep my appointment may result in poor fitting dentures or partials.

ORTHODONTICS - Our doctors are experienced/ trained in the provision of Invisalign orthodontic treatment. It is the patients responsibility to be 100% compliant with instructions and homecare for the treatment to be successful. I understand that additional fees may be applied if refinement of the treatment is needed. The cost of the retainers are not included in the initial invisalign treatment fee.

ACKNOWLEDGMENT

1. I certify that the answers to the health questionnaire are accurate and correct to the best of my knowledge. Since a change of medical conditions, pregnancy or medications can affect dental treatment, I understand the importance of and agree to notify the doctor and associates of any changes at any subsequent appointment.

2. 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 I have requested and authorized.

3. I hereby authorize the doctors of St. Albans Dental and Associates 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 unforeseen or undiagnosable circumstances that may arise during the course of treatment.

4. 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 incurred to satisfy this obligation.

Patient (guardian if patient is a minor) Date

Witness signature Date