Four States Dental Care

Consent for Dental Treatment

Dale A. Kunkel, DDS & Associates

Neosho - Monett

_____ _____

Patient's Name Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR OR TEAM MEMBER BEFORE INITIALING.

____ 1. TREATMENT:

I understand that I agree to have the following dental treatment performed:
Fillings, Crowns, Bridges, Dentures, Extractions, Impacted tooth removal, Root Canals, Regular or Mini Implants, treatment of periodontal disease or any other work deemed necessary.

____ 2. DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissue, itching, pain, nausea, vomiting or more severe adverse reactions. I have informed the doctor of any know allergies. Certain prescribed medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

____ 3. RISKS OF DENTAL ANESTHESIA:

I understand that pain, brushing and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with local anesthetic (shots). About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

____ 4. FILLINGS:

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns. I understand that sensitivity may be present for an indeterminate amount of time afterwords.

____ 5. CROWNS, BRIDGES, INLAYS AND ONLAYS

I understand that it is sometimes impossible to exactly match the color of the natural teeth with that of artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

____ 6. DENTURES:

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that, while I no longer suffer from dental decay or infection, I could experience denture related problems such as shrinking of bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time and there is a small number of patients who never do. Immediate Dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

____ 7. EXTRACTIONS:

Alternatives to tooth removal include Root Canal Therapy, extensive restoration, Periodontal (gum) treatment, crowns or any other work deemed necessary. I understand that removing teeth does not always remove existing

infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, loss of feeling in my lip or other facial areas, cheek, tongue, gums, and teeth. Such numbness may be temporary or permanent. Damage to adjacent structures is also possible. Also, there is the possibility of a small root piece being left in the jaw when the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment and that costs incurred are my responsibility.

____ 8. PERIODONTAL DISEASE:

Periodontal disease can be a serious condition and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including gum therapy, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instructions, including strict observance of hygiene maintenance appointments. I understand that care by a specialist may be necessary.

____ 9. ROOT CANAL THERAPY:

I realize root canal therapy has a high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include, but are not limited to, extensive decay making the tooth unrestorable, perforations, a fracture tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough and might need further surgery or treatment by a specialist are additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which if not placed right away, might lead to fracture of the tooth and possible extraction.

____ 10. MINI OR REGULAR DENTAL IMPLANTS:

I understand the purpose of dental implant procedure is to replace a missing tooth provide support to an existing denture or partial denture. In the event that the implants fail, they will be removed through subsequent surgical procedure. I understand that one or more of the implants may fracture during insertion or during the implant's life cycle. If a fracture occurs, I give consent to leave the implant in my jaw or remove it, under professional conditions and using professional judgement. I further understand that swelling, infection, bleeding and/or pain may be associated with this or any surgical procedure, and that said conditions may occur during the life of the implants. I also understand that temporary or permanent numbness may occur in my tongue, lip(s), chin, gum, or jaw as a result of this procedure.

____ 11. CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Doctor's or Team Member's Signature Date