REV2021

San Gabriel Valley Foundation for Dental Health

General Dentistry Informed Consent

Patient's Name: _____ **Date of Birth**: _____

Exam & X-Rays (Initials_____)
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

Drugs and Medications. (Initials_____)
I understand that antibiotics and analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, Pain, Itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Changes in Treatment Plan (Initials_____)
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 examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary

Fillings (Initials_____)
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling, than initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filing.

Removal of Teeth (Initials_____)
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infections, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infections, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist of even hospitalizations if complications arise during or following treatment, the cost of which is my responsibility.

Periodontal Disease (Tissue & Bone) (Initials_____)
I understand that my child could have a gum disease causing gum inflammation, bleeding and/or bone loss, and that it can lead to the loss of teeth. Alternative treatment plans have been explained to me, including Non-surgical cleaning, 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 cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

Endodontic Treatment (Root Canal) (Initials_____)
I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy).

I understand that dentistry is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an Individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist or San Gabriel Valley Foundation for Dental Health is responsible for my dental treatment.

Signature of Patient/ Guardian _____ Date_____

Signature of Patient/ Guardian _____ Date_____

Signature of Patient/ Guardian _____ Date_____

Signature of Patient/ Guardian _____ Date_____