# GENERAL DENTISTRY INFORMED CONSENT FORM

Office/Patient #: _________________________________ Patient Name: _______________________________

## 1. TREATMENT TO BE PERFORMED

I understand that I will receive a dental examination, including necessary X-rays and other diagnostic procedures to develop a comprehensive treatment plan. I have completed a medical history form and reviewed past and present medical conditions with the dentist. I acknowledge that if a referral to a specialist is required, I am responsible for the associated costs.

Initials: _______

## 2. DRUGS AND MEDICATIONS

I acknowledge that prescribed medications, such as antibiotics and pain relievers, may cause allergic reactions, including redness, swelling, itching, nausea, or, in rare cases, anaphylactic shock. I am responsible for informing my dentist of any known allergies to medications.

**Local Anesthetics:** I understand that local anesthetics may contain epinephrine, which can temporarily increase heart rate. Common side effects include pain, swelling, or bruising, while rare complications may include prolonged numbness, abnormal sensations, or, in extremely rare cases, severe reactions.

Initials: _______

## 3. CHANGES IN TREATMENT PLAN

I understand that unforeseen conditions may arise during treatment, requiring modifications to the procedure. The most common instance is the need for a root canal after beginning routine treatment. I consent to necessary changes after being informed and providing consent. I also acknowledge that delaying recommended treatment may lead to increased discomfort, complications, or even tooth loss.

Initials: _______

## 4. TOOTH EXTRACTION

I consent to the removal of teeth as deemed necessary to address dental disease or other conditions. Risks associated with extractions may include:

• Postoperative discomfort, swelling, or prolonged bleeding.

• Injury to surrounding teeth, restorations, or oral tissues.

• Jaw stiffness, bite changes, or potential nerve injury causing temporary or permanent numbness.

• Possible bone fractures or sinus complications requiring additional treatment.

If an unforeseen condition arises, I authorize the dentist to take appropriate action, including referral to a specialist.

Initials: _______

## 5. CROWNS, BRIDGES, INLAYS, ONLAYS, VENEERS, AND CAPS

I understand that crowns, bridges,inlays, onlays, veneers, and caps restore damaged teeth. Temporary crowns may come loose and require re-cementation. I acknowledge that my final opportunity to request modifications to the shape, fit, or color of the restoration is before permanent placement. Failure to attend my scheduled appointment may result in improper fit, requiring additional costs.

Initials: _______

## 6. DENTURES (FULL OR PARTIAL)

I understand that full or partial dentures are artificial replacements for missing teeth and may cause discomfort, looseness, or breakage. Changes to the fit, size, or color must be made during the “teeth in wax” try-in visit. Relining may be necessary within six months and annually thereafter, and I acknowledge that these costs are not included in the initial fee.

Initials: _______

## 7. ROOT CANAL TREATMENT (ENDODONTICS)

I understand that a root canal treats an infected tooth but does not guarantee the tooth’s long-term viability. A crown is typically required to protect the tooth from fracture. Risks include:

- Temporary or persistent discomfort, swelling, or restricted jaw movement.
- Instrument separation or root perforation, potentially requiring additional procedures.
- Overfilling or underfilling of the root canal, affecting treatment success.

Initials: _______

## 8. PERIODONTAL DISEASE (GUM DISEASE)

I acknowledge that untreated gum disease can lead to tooth and bone loss. I understand that treatment options, including deep cleaning (scaling and root planing), medication, surgery, or tooth extraction, have been explained to me. I also understand that maintaining oral hygiene and regular dental visits are essential for long-term success.

Initials: _______

## 9. FILLINGS

I understand that dental fillings restore decayed teeth. In some cases, additional treatment such as a crown or root canal may be required. Sensitivity and discomfort after a filling are normal but should improve over time. If symptoms worsen, further treatment may be necessary.

Initials: _______

## 10. PEDIATRIC DENTISTRY (For Parents/Guardians)

I give consent for the following behavior management techniques when necessary for my child’s treatment:

- Positive Reinforcement: Praise or rewards for cooperative behavior.
- Voice Control: Adjusting vocal tone to guide behavior.
- Physical Restraint: We will not physically restrain your child. Should they be unable to complete an examination, dental, x-rays, or any diagnosed dental treatment; they will be referred to a specialist’s office.

I understand that local anesthesia may result in my child accidentally biting their lips, tongue, or cheeks, potentially causing injury.

Initials: _______

## CONSENT AND ACKNOWLEDGMENT

I acknowledge that:

- No guarantees have been made regarding treatment outcomes.
- I have read and understand this consent form.
- I have had the opportunity to ask questions, and all my concerns have been addressed.
- I give my consent for the indicated procedures to be performed by the dental team.

Patient Signature: ___________________________ Date: _______________

Doctor's Signature: ___________________________ Witness:______________