san diego dental studio

Dr Tom Bierman | Dr Quan Ma

Informed Consent

1. Changes to the Treatment Plan: I understand that during dental 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 treatment plan can either increase or decrease the original estimate. I understand that I will be informed of the recommended change and will have the opportunity to accept or decline the procedure.

   (Initials_____)

2. Potential risks/side effects of treatment: I understand that symptoms of popping, clicking, grinding, locking, and pain can intensify or develop in the joint of the lower jaw (TMJ) subsequent to routine dental treatment, wherein the mouth is held in the open position. Although symptoms of Temporo-mandibular joint dysfunction associated with dental treatment are usually temporary in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I may be referred to a specialist for treatment, the cost of which is my responsibility. Additionally, I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, or cardiac arrest. Occasionally, injection of a local anesthetic may cause prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

   (Initials_____)

3. Hygiene and cleanings: I understand that the long term success of any dental treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e brushing and flossing) and maintaining regular recall interval visits as recommended by the doctor or hygienist.

   (Initials_____)

4. Periodontal Treatment: I understand that if I have a condition causing gum inflammation and/or bone loss, which can lead to the loss of my teeth, alternative treatment plans will be explained to me, including non-surgical “deep cleaning”, gum surgery, and/or extractions. I understand that the success of any treatment plan depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations as received.

   (Initials_____)

5. Fillings: I understand that sensitivity to cold is common following the placement of a new filling and usually passes within one to two weeks. It has been explained to me that, in very few cases, teeth receiving any type or restorative dental treatment may require the need for root canal treatment. The need for root canal treatment cannot always be predicted and involves an additional fee. The advantages and disadvantages of different filling materials has been explained to me.

   (Initials_____)

6. Crowns, Bridges, Onlays, Inlays, Veneers, and Bonding: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth or filling material. I further understand that I may be wearing temporary crowns, which may come off, 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 other restoration will be prior to cementation. It has been explained to me that, in very few cases, dental procedures may result in the need for future root canal treatment, which cannot always be anticipated. I understand that cosmetic procedures require excellent oral hygiene to prevent recurrent decay and periodontal disease (bone loss).

   (Initials_____)

I understand that dentistry is not an exact science, and therefore, that reputable, ethical practitioners cannot 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 realize that my treatment plan is an estimate and can change due to unforeseen circumstances. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Name (printed) _____

Signature _____ Date _____

Staff Signature _____ Date _____