Patient Name:

GREEN DENTAL
GENERAL & COSMETIC

Dr. Maridette Cunanan, D.D.S.
3731 Wilshire Blvd. Ste. 625
Los Angeles, CA 90010
Office Phone: (213) 381-3738
Email: lagreendental@gmail.com

INFORMED CONSENT

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

{ }In reading and singing this form, it is understood that ENGLISH is the language that I understand and use to communicate.

(Initials/Date)_____

{ }1. EXAMINATION AND X-RAYS

I understand that initial and periodic visits may require radiographs and photographs in order to complete the examination, diagnosis, and treatment plan.

(Initials/Date)_____

{ }2. REGULAR HYGIENE

I understand that the long term success of treatment and status of my oral condition depends on my efforts of proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

(Initials/Date)_____

{ }3. MEDICATIONS AND ANESTHESIA

I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effective treatment of my condition. I have been informed and understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and a lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

(Initials/Date)_____

{ }4. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures found while working on teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures, which is to be discussed in detail.

(Initials/Date)_____

{ }5. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials/Date)_____

{ }6. PERIODONTICS (TISSUE AND BONE LOSS)

A "deep cleaning" has been recommended for me. I understand that I have a **serious condition** causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and other complications especially without treatment. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed.

(Initials/Date)_____

{ }7. FILLINGS AND COSMETIC BONDING

I have been advised of the need for fillings to replace tooth structure lost to decay. I understand that with time, fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that care must be exercised in chewing on the new filling during the first 24 hours, and tooth sensitivity is a common after-effect of a newly placed filling.

(Initials/Date)_____

{ }8. CROWNS, BRIDGES, VENEERS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crown, bridge or veneer (including shape, fit, size, placement, and color) will be done before cementation.

I understand that at times, during the preparation of a tooth for a crown, bridge, or cosmetic procedure, pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crowns, bridges, and veneers need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials/Date)_____

{ }9. ENDODONTIC TREATMENT (ROOT CANAL)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment.

(Initials/Date)_____

I understand that following root canal therapy, my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I realize there is no guarantee that root canal treatment will save my tooth; and I understand the treatment risks and complications can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instruments during treatment, which may in the judgement of the doctor be left in the treated root canal or bone as part of the filling material, or may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in the treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized, I expose myself to infection and/or tooth loss.

I understand that if failure or root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required (apicoectomy), or the tooth may have to be extracted.

(Initials/Date)_____

Patient Name:

{)10. REMOVAL OF TEETH (EXTRACTIONS)

I understand the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

(Initials/Date)_____

An alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I give my consent for the doctor to remove the following teeth as discussed _____. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. If any unforeseen condition should arise in the course of the operation, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist, the cost of which is my responsibility.

(Initials/Date)_____

I understand the risks involved in having teeth removed, some of which include but are not limited to the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection, which may require prescription medication or additional treatment (i.e. surgery).
B. Injury to adjacent teeth, caps, or fillings (requiring the recementation or new fabrication of crowns, replacement of fillings, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular (jaw joint) dysfunction possibly requiring physical therapy or surgery.
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth, resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks; months, or, in remote instances, permanently.

(Initials/Date)_____

{ }11. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The potential problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit.

Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor. I understand that most dentures require relining approximately three to twelve months after. The cost of this procedure is NOT included in the initial denture fee.

I further understand that surgical intervention (i.e. tori/bone removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials/Date)_____

{ }CONSENT: I have read each paragraph above and consent to recommended treatment as needed (as highlighted for me by the doctor and/or staff). I understand the anticipated benefits and commonly known risks and complications of each procedure.

Print Patient Name: _____

Patient Signature and Date: _____

Parent/Legal Guardian Name and Date: _____

Witness Sign and Date: _____