SMILE DESIGN CENTER

RESTORATIVE AND ROOT CANAL TREATMENT PATIENT INFORMATION AND CONSENT FORM

1. I have been informed and I understand the purpose and the nature of the restorative/root canal procedure. Restorative procedure includes fillings, build-ups, crowns, inlays and onlays. I understand what is necessary to accomplish during the restorative/root canal procedure.
2. My doctor has carefully examined my mouth. Alternatives to these treatments have been explained. I have considered these alternatives, but I desire to proceed with the recommended treatment.
3. I have further been informed of the possible risks and complications involved with the restorative/root canal procedure and anesthesia. Such complications include pain, swelling, infection, discoloration. In extremely rare case prolonged or permanent numbness of the lip, tongue, chin, cheek, or teeth may occur as a result of a local anesthesia. Also, possible are inflammation of a vein, injury to teeth present, allergic reactions to drugs or medications used, etc.
4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, fracture of teeth, loss of teeth. Also possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles when chewing.
5. It has been explained that in some instances root canals or restorations may fail. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment can be made.
6. I understand that smoking, excessive sugar, lack of dental cleanings and poor brushing/flossing may affect the longevity of placed restorations. I agree to follow my doctor's gum care instructions, including regular dental cleanings. I agree to report to my doctor for regular examinations as instructed.
7. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device while taking the prescribed pain medication or the antianxiety medication. I agree to take antibiotic medication as prescribed.
8. To my knowledge I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs (including anesthetics), blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. I consent to photography and video recording of the procedure to be performed for the advancement dentistry, provided my identity is not revealed. Check if you do not give permission _____.
10. I request and authorize medical/dental services for myself, including restorative procedures and root canal treatment. I fully understand that during and following the contemplated procedure, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in designs, materials, or care, if it is felt this is for my best interest.

Signature of Patient	Date	Signature of Witness	Relationship to Patient

Signature of Doctor	Date