**DENTAL CONSENT FORM**

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

It is very important that you provide the Dentist with an accurate medical history before, during, and after treatment. It is equally important that you follow the Dentist’s recommendations and advice 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 the 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 the Dentist has addressed all of your concerns to your satisfaction before commencing treatment.

1. **DENTAL CARE**. The following care may be provided to you during your course of treatment:

Examinations and X-Rays. Radiographs are required to complete your examination, diagnosis, and treatment plan. A periodic examination will be provided by the Dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer, and overall health. The Dentist will read and diagnosis any x-rays taken.

Dental Prophylaxis (Cleaning). A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature, the office should be contacted.

Restorations (Fillings). A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown, or both. Sensitivity is a common aftereffect of a newly placed filling. Occasionally after receiving a filling, it may feel high and you may need to return to have the bite adjusted.

Periodontal Treatment. Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dental hygienist and Dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment, it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning below the gum line, placement of an antibiotic below the gum line, or a gross debridement (two part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow any other recommendations. Some bleeding after deep cleaning or scaling under the gum line can occur, however, should it persist and if it is severe in nature, the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Crowns, Bridges, and Veneers. It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful chewing on them until the permanent crowns are delivered. If a temporary crown should fall off, call the office immediately. The final opportunity to make changes on crowns, bridges, or veneers (including shape, fit, size, placement, and color) will be done before permanent cementation. In some cases, crowns, bridges, and veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown, bridge, or veneer is permanently cemented, sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleaning procedures may be required, and if so, will be explained to you by the provider.

Temporomandibular Joint Dysfunction (TMD). 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 when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If the need for treatment should arise, a plan will be developed and discussed, if you are diagnosed with Temporomandibular Joint Disorder, specialized treatment maybe necessary; the costs of which will be your responsibility.

1. **CHANGES IN TREATMENT PLAN**. 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 fillings covering more surfaces of the tooth or root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
2. **ALLERGIES/MEDICATION**. I have informed the Dentist of any known allergies I may have. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain, or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).
3. **CONSENT**. I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure. I also understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

I authorize Dr. Kelly Halle Brown and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitive reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one’s mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

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**Patient Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_