PRIME Dental
Dr. Tatiana Lucas, DDS
272 Cross Roads Plaza,
Mount Pleasant, PA 15666

GENERAL CONSENT FORM

Patient name: _____Date:_____
Last, First, Initial

1. MEDICAL HISTORY AND MEDICATIONS INFORMATION

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines/drugs that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any allergies you have.

2. X-RAYS AND PHOTOS

The initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

3. MEDICATION ADMINISTRATION AND SEDATION

I have been informed and understand that anesthetics, analgesics and antibiotics and other medications used in dentistry, although rare, can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. Failure to take medications prescribed in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I have informed the Dentist of any known drug allergies.

4. RESTORATIONS

I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is common after effect of a newly placed fillings. In the case of patient having deep decay near the tooth nerve, there is a high risk of developing sensitivity and the need for root canal treatment may arise. If this need occurs during the decay removal, the dentist will discuss further treatment options with the patient.

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. In case of diagnosis of periodontal disease, the dentist will discuss further treatment options with the patient.

6. SPECIFIC PROBLEM EXAMINATION

In the event that a patient requests only a specific problem to be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. In this case the dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a comprehensive exam.

7. 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 teeth that could not be discovered during examination. A more extensive treatment plan than originally diagnosed and proposed may be required due to additional decay or unsupported tooth structure found during preparation of the tooth. This may lead to other measures necessary to restore the tooth to normal function including the need for root canal, crown, or both. I do authorize the performance of additional procedures and changes of planned

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procedures if, in the judgment of the doctor, this will be necessary to improve my safety and result. I give my permission to the Dentist to make any/all changes and additions as necessary after discussion with a dentist.

8. COMPLICATIONS

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent). Although extremely rare such conditions as Bell's Palsy and Trigeminal Neuralgia may occur due to use of injections and local anesthetics. Reaction to injections, changes in occlusion (bite), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure are a possible risks of any dental procedure.

9. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that 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. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

10. SPECIALTY REFFERAL AND/OR SECOND OPINION

General dentists perform the majority of all dental treatments today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

AKNOWLEDGEMENT

I hereby authorize the dental staff of Prime Dental to proceed with and perform the dental restorations and dental treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that dentistry is not an exact science and although favorable results are expected, no guarantee or warranty of expectations, refunds of any kind, either expressed, or implied, has been made. This is due to human variables associated with individual healing and responses to surgery and recovery. Likewise, I understand that, although unexpected, risks and complications can occur. The associated risks of surgery and anesthesia have been explained to me.

I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions.
I consent to allow staff of Prime Dental to take x-rays and perform an examination on me today.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness

Patients Initials_____