GENERAL CONSENT FORM

_____
Patient Name (Last, First MI)

CAMBRIA SMILES

2150 MAIN STREET # 4
CAMBRIA CA 93428
805-927-4811

1) CHANGES IN TREATMENT PLAN. I understand that as treatment progresses it may be necessary to change or add procedures due to conditions found during the process of treatment that were not readily evident at the exam and diagnosis phase of treatment and of which could require care by a specialist, the cost of which is my responsibility. I give my consent to these changes or additions. I understand that even minor treatment can result in sensitivity and even a routine procedure can necessitate root canal therapy. **Initial _____**

2) MEDICATIONS & ANESTHETICS. I understand that antibiotics, analgesics, anesthetics, medications and other dental supplies/products may be part of treatment and can cause allergic reactions (redness, swelling, pain, itching, vomiting and/or anaphylactic shock) and can change the effectiveness, duration and interact with other medications taken. The injection of anesthetic can cause temporary or indefinite changes in feeling (paresthesia) and motor control. **Initial____**

3. REMOVAL OF TEETH (EXTRACTION). Alternatives to the removal of teeth have been explained to me as applicable (root canal therapy, crowns, periodontal surgery - etc.) and I authorize the removal of Treatment Planned teeth and any others necessary (see paragraph #1). I understand the risks include pain, swelling, discomfort, the spread of infection, dry socket, paresthesia, (a change in feeling in my teeth, lips, tongue and surrounding areas that can be permanent in nature) and/or changes in motor control. I understand removing teeth does not always remove all of the infection and infection caused changes. These and Other complications that may occur during or following treatment may require further treatment by a specialist or even hospitalization, the cost of which is my responsibility. **Initial _____**

4) ROOT CANAL (ENDODONTIC TREATMENT). I understand that a root canal is an attempt to save a tooth and that complications (calcified canals, inaccessible canals, perforation & loss of the canal during treatment, instrument separation in the canal and/or fracture of the tooth crown, body or root) can occur. Other complications can include a reaction to a medication used, pain, swelling, continued infection and sensitivity to pressure even after treatment is completed. These and other complications that may occur during or following treatment may require further treatment (including retreatment, surgery on the root and/or extraction) by a specialist, the cost of which is my responsibility. **Initial _____**

5) FILLINGS. I understand that as treatment progresses, as in any restorative procedure, the cavity (caries) may be greater than expected. **Initial _____**

6) INLAYS, VENEERS, CAPS (CROWNS) AND BRIDGES. I understand that it is not possible to exactly match the color of natural teeth. I realize that the time to request changes (in color, shape, fit and size) is prior to cementation. I realize that permanent crowns are fabricated from materials that can be susceptible to fracture.

I understand that the temporary placed interim to the placement of the permanent is fragile in nature and care must be taken not to break or dislodge it. The temporary is constructed to last only two to three weeks; postponing the placement of the permanent can allow tooth movement, necessitating a remake at an additional charge. **Initial_____**

7) DENTURES-COMPLETE OR PARTIAL. I understand problems in wearing dentures can include looseness, sore spots, decreased ability to speak/eat and breakage. Immediate dentures (dentures placed at the time of the extractions) have more discomfort and require additional adjustments. I realize that the time to request changes (in color, shape, fit, and size) is at the "teeth in wax" visit. Relines (at an additional fee) will be required as a denture loosens with tissue shrinkage. **Initial _____**

8) GUM (PERIODONTAL) TREATMENT. I understand that I have a serious and progressive disease that can lead to acute infection, pain and tooth loss. Treatment can include cleanings (scaling), deep cleanings (root planning), periodontal surgery (by referral to a specialist) and teeth considered hopeless or teeth that do not respond favorably to treatment will require extraction. I understand that post-therapy my teeth may be sensitive to cold and sweets. I understand that postponement of care and other factors including the quality of home care can affect my ability to retain my natural dentition. **Initial _____**

9) IMPLANTS. I understand that implants have three main parts: an Implant (root form), abutment (connection between implant and restoration) and restoration (supra structure/crown) portion. Poor healing or infection at the surgical site can lead to acute infection, pain and loss of the abutment and/or adjacent teeth. The restorative portion also may come lose or fracture requiring replacing screws or collars, recementation and/or complete loss of the suprastructure. Replacement of the abutment or suprastructure are additional procedures, the cost of which is my responsibility. I understand that smoking and teeth grinding greatly increases the risk of implant failure. **Initial _____**

I understand that dentistry is as much an art as a science and because of this it is impossible to predict the outcome of treatment. I authorize my treating dentist(s) to proceed through the use of medications, materials and therapy as deemed appropriate as treatment progresses.

I have no unanswered questions about treatment benefits/risks, or alternative treatment(s) and their benfits/risks. **I** have read, understand and agree to the above.

Patient Signature _____ Date _____

Witness_____

(If minor * parent or guardian) Signature - First MI Last

Patient No-Show Policy

When an appointment is made, it is the patient's responsibility to keep the appointment or cancel at least 24 hours prior to the appointment. When a patient no-shows for an appointment, another patient who needs treatment is unable to receive it. A Monday morning appointment must be cancelled by 2 pm on Friday. As has been the policy for some time missed appointment fee will be charged as follow:

Exams, evaluations and cleaning appointments will be 50.00 dollars.

Procedure appointments with Doctor or hygienist will be 100.00 dollars

THANK YOU FOR YOUR CONIDERATION.

Patient Signature_____Date _____