

# **Informed Consent Form for General Dental Procedures**

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

- |   |   |
|---|---|
| 1.) Pain, swelling, and discomfort after treatment;   | 8.) Allergic reaction to anesthetic or medication;  |
| 2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;                             | 9.) A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later point in time;                                  |
| 3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste; | 10.) If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment; |
| 4.) Damage to adjacent teeth, restorations or gums;   | 11.) Infection in need of medication, follow-up procedures or other treatment;  |
| 5.) An altered bite in need of adjustment;  | 12.) The need for replacement of restorations, implants or other appliances in the future;  |
| 6.) Possible deterioration of your condition which may result in tooth loss;  | 13.) Need for follow-up care and treatment, including surgery;  |
| 7.) Jaw fracture;   | 14.) Prolonged numbness.  |

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advise and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications or recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of parent (if a Minor) or Legal Guardian

\_\_\_\_\_  
Date

**GENERAL CONSENT**

## **Information Regarding Bisphosphonates**

Bisphosphonates are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24<sup>th</sup>, 2004.

It is very important for you to let us know if you are now, or have ever taken in the past, ANY type of bisphosphonate class drug. If we treat you without knowing if you are now taking, or have taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but may not be limited to) are:

Fosamax  
Zometa  
Aredia  
Actonel  
Boniva  
Bonfos  
Skelid  
Didronel

**Are you now, or have you in the past, taken a bisphosphonate drug, including any of the brands above?**

YES \_\_\_\_\_ NO \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## **Information on the Election of Treatment Options**

Your dentist will design a treatment plan in which he/she will recommend that you undergo specific dental procedures. You will be presented with the optimum treatment for your particular dental needs. If, in the dentist's judgment, other acceptable treatment options exist, these will be discussed with you as well. There are likely to be increased risks and potential complications should you elect to have an alternative form of treatment that differs from the optimum treatment plan presented to you. Please discuss these issues in more detail with your dentist. Be sure to understand the potential risks and complications before consenting to treatment.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of parent (if a Minor) or Legal Guardian

\_\_\_\_\_  
Date