River Hills Dentistry, P.A.
General, Family and Cosmetic Dentistry
Robert C. Reid, D.D.S.

GENERAL DENTISTRY INFORMED CONSENT

DENTAL TREATMENT

I understand that I am having dental work done, such as dental examination, radiographs or x-rays, photographs, local analgesia or "novocaine"-type anesthetic, non-amalgam restorations or fillings, bridges, crowns or caps, cleanings or periodontal care, root canals, extractions, removable partials, dentures, tooth whitening, cosmetic restorations, implants or other dental care.

DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, including redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. I understand it is my responsibility to inform the doctor of any known allergies or medications I have.

CHANGES IN TREATMENT PLANS

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. I understand that delay in time from examination to treatment may alter conditions and treatment necessary.

REFERRAL

I understand that conditions or circumstances may arise that the dentist will recommend and referral of my treatment to a specialist in that area of dentistry. I understand that medical needs may require referral to a physician for evaluation prior to or during treatment planned.

FILLINGS

I understand that tooth-colored fillings will be used and that amalgam(silver) filling are an alternative available by other dentist office's. I understand that care must be exercised in chewing on fillings to avoid breakage. I realize that a more extensive filling than originally diagnosed may require full coverage with a crown at additional expense. I understand that sensitivity is a common after effect of fillings.

REMOVAL OF TEETH

Alternatives to removal have been explained (root canal therapy, crown, periodontal surgery, etc.). I understand removing teeth does not always remove all infection, if present and it and it may be necessary to have further treatment. I understand there are risks involved in having teeth removed, some are pain, swelling, spread of infection, "dry socket" or alveolitis, Bisphosphonate-associated Osteonecrosis of the jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time, or a fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which are is my responsibility.

CROWNS AND BRIDGES

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns or bridges, which may come off easily, and that I must be careful to ensure that they are kept on until the final crowns are delivered. I understand the final opportunity to make changes in my new restoration will be before cementation.

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ROOT CANAL THERAPY

I understand there is no guarantee that root canal treatment will prevent loss of my tooth and that complications can arise during and after treatment. I understand that occasionally root canal filling material may extrude through the root, which does not necessarily affect the success of treatment. I understand that referral for surgical procedures may be necessary following root canal therapy(Apicoectomy). I realize that the tooth may be lost despite all efforts to save it.

PERIODONTAL TREATMENT

I understand that periodontal disease is a serious condition causing gum and bone loss or inflammation and that if allowed to progress can lead to tooth loss. Alternative treatment plan have been explained, including the possibility of referral for periodontal surgery, replacement and/or extractions.

REMOVABLE PARTIALS and DENTURES

I understand the wearing and use of removable partials and/or dentures is difficult. Sore spots, altered speech and difficulty eating are common problems with artificial teeth and gums. New prostheses will require adjusting and possibly relining in the future which will be an additional expense I am responsible for. I agree it is my responsibility to return for delivery of partials and dentures in a timely manner. I understand that failure to keep my appointments and adjustments may result in poorly fitting dentures and that I must wear them when delivered. I understand excessive delays may result in additional lab fees to complete the partial or denture.

BISPHOSPHONATES

I have been advised by my physician and dentist that bisphosphonates such as Aredia,Bonefos,Zometa, Actonel, Didronel, Fosamax, and Boniva have been associated with a rare spontaneous development of osteonecrosis of the jaw, a condition causing suffering from destruction or loss of jaw bone after dental surgery. I have disclosed the use of any of these medications including past use of any bisphosphonate.

I understand that the art of dentistry is not a exact science and that no ethical practitioner can totally guarantee results. I acknowledge that no assurance or guaranty has been made or implied regarding the dental treatment, which I have requested and authorized. I understand that I am authorizing the dentist of River Hills Dentistry, PA to proceed with and perform the dental treatment and restorations as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. 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 fee, or court costs that may be incurred to satisfy this obligation.
Should any dispute arise over dental services provided to me, that is whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly, negligently or incompletely performed, said dispute will be submitted to Peer Review by the Hillsborough County Dental Association. The decision of Peer Review shall be binding on both parties.

I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original, forever. I am of legal age and legally competent to make this assignment.

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Signature Date