STAR DENTAL GROUP

13061 Rosedale Hwy, Ste B, Bakersfield, Ca 93314, (661) 588 5511, Fax (661) 588 5522

GENERAL DENTISTRY INFORMED CONSENT

DENTIST:…RANJAN RAJBANSHI, DDS…….. **PATIENT:**……..……

1.- WORK TO BE DONE
I understand that I am having the following procedures performed: Fillings ( ), Crowns( ),Bridges( ), Extractions( ), Root Canals( ), Periodontal Treatment( ), Dentures( ), Orthodontic Treatment ( ), Others( ) (Initials : ……)

2. DRUGS AND MEDICATION
I understand that antibiotics, anesthetics, analgesics and other medications can produce allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Some medications that I might be currently taking could produce undesired effects or interfere with the normal process of healing (for example aspirin could produce excessive bleeding during extractions, etc). I understand that filling the health questionnaire out to the best of my knowledge is important in order to be prepared for any recommended procedure. (Initials : ……)

3. CHANGES IN TREATMENT PLAN
I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, I may need root canal therapy following routine restorative procedures or extraction of a tooth previously treated with root canal treatment. The dentist will explain all changes. (Initials :……)

4 REMOVAL OF TEETH
Alternatives, benefits and consequences to the removal of teeth (root canal therapy, crowns, and periodontal surgery) have been explained to me and I authorize the dentist to remove the following teeth ……..If any others extractions are necessary the dentist will explain it according to the paragraph #3 before the procedure. I understand that removing teeth may not always remove all the infection present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility (Initials : ……)

5. CROWNS, BRIDGES AND CAPS
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, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement or recurrent
decay. This may necessitate a remake of the crown, bridge, or cap. I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that the remaking of existing crowns or bridges imply certain risks like pulp involvement, fracture of root, etc; that could lead to further unexpected procedures.(Initials : ……)

6. ENDODONTIC TREATMENT (ROOT CANAL)
I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling may extend beyond the tooth root which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it. (Initials: ……)

7 PERIODONTAL TREATMENT
I understand that I have a condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including Deep cleaning, gum surgery, locally administered antibiotics, bone replacements and/or extractions. I also understand that the success of the periodontal treatment depends not only on the procedure performed but also on the daily personal care.(Brushing and flossing) (Initials: ……)

8. FILLINGS
I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done. I understand that sometimes it is not possible to match the color of natural teeth exactly with white fillings (Composites) especially when replacing existing metal fillings. (Initials : ……)

9. DENTURES
Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. I understand that (Initials : ……)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot completely guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. 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 fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient (Parent or Guardian) ……..…… **Date** …..……..…..

Signature of Doctor:..... **Witness**……