ACCELERATED DENTAL

Dr Rick Copithorne
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Informed Consent for Dental Treatment

X-RAYS

Proposed treatment: taking of intraoral and extraoral radiographs. ***Benefits of treatment:*** taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purp oses. ***Alternatives of treatment:*** none; limited visual examination. ***Common risks:*** radiation exposure to soft and hard tissues. Consequences of not performing the treatment: missed diagnosis.

CLEANING

Proposed treatment: involves thorough cleaning of teeth to help heal inflamed of infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. ***Benefits of treatment:*** healthy oral environment; also, reduction/elimination of bleeding, odor, and periodontal disease. ***Alternatives of treatment:*** referrals for periodontal (gum) surgery according to the severity of condition. ***Common risks:*** bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint. ***Consequences of not performing the treatment:*** discontinued or interrupted treatment could result into further inflammation and infection of gum tissues; lead to more tooth decay, and deterioration of surrounding bone structure which co uld lead to tooth loss.

ANESTHETIC

Proposed treatment: injection of anesthetic to surrounding oral tissues. ***Benefits of treatment:*** numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation. ***Alternatives of treatment:*** dental restorations performed with no anesthetic resulting in severe sensitivity and pain. ***Common risks:*** allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising, and may cause temporary or permanent paralysis. ***Consequences of not performing the treatment:*** severe pain and sensitivity.

FILLINGS

Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy. ***Benefits of treatment:*** restore tooth structure for proper function. ***Alternatives of treatment:*** temporary filling, crown, extraction. ***Common risks:*** allergic to filling material, tooth sensitivity, filling may come out.
Consequences of not performing the treatment: further spread of decay, requiring root canal treatment or severe destruction resulting in tooth loss.

ROOT CANAL TREATMENT AND PULPOTOMY

Proposed treatment: to remove pulp tissue and replace with root canal filling material. ***Benefits of treatment:*** eliminate pain, infection, swelling and further destruction of tooth structure. ***Alternatives of treatment:*** extraction. ***Common risks:*** recurrence of symptoms, breakdown of tooth structure. ***Consequences of not performing the treatment:*** increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

CROWN AND BRIDGE

Proposed treatment: to strengthen a tooth damaged by decay or previous restoration, and protect a tooth that has had a root canal treatment. Improve the biting surface, appearance of damaged, discolored, poorly spaced and/or missing teeth. ***Benefits of treatment:*** to restore or improve the appearance and strength of teeth. ***Alternatives of treatment:*** extraction of Orthodontic treatment (only in proper spacing, not damaged teeth). ***Common risks:*** irritation to surrounding tissue, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment. ***Consequences of not performing the treatment:*** further destruction, nerve exposure, loss of tooth function, root canal treatment.

EXTRACTION

Proposed treatment: removal of unrestorable tooth structure and roots. ***Benefits of treatment:*** elimination of pain, infection, swelling.
Alternatives of treatment: none. ***Common risks:*** infection, bleeding, soreness, bruising, damage to adjacent teeth and soft tissue, dry socket, opening into sinuses, tooth and bone fragments, bone fracture, chronic hot and cold sensitivity, temporary and or permanent numbness, and destruction of bone and soft tissue. ***Consequences of not performing the treatment:*** severe pain, swelling, infection, possible hospitalization with rare cases of death.

I have read and understood the entire information on this consent form, which includes x-rays, cleanings, anesthetics, fillings, root canal treatment, pulpotomy, crown, bridge, and extraction. All my questions were answered to my full understanding and satisfaction.

Signature of patient, parent, or legal guardian _____ Date _____

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WELCOME TO ACCELERATED DENTAL

We realize you have many choices for your dental care and do appreciate you choosing our office for your dental needs. At Accelerated Dental, we are committed to providing you with the highest quality, state of art dentistry, in a manner that is comprehensive, compassionate and cost-effective.

____PAYMENTS **(Please initial)**
Payments are due at the time of service. For your convenience, in addition to cash and cashier checks, we accept Visa, MasterCard, Discover Card and American Express. Interest free financing for those who qualify may be applied for through one of several financing programs we have to offer. Our staff can help you with the application. To ensure proper scheduling, a 50% deposit for all major procedures must be made prior to the scheduled date. The remaining balance will be collected via insurance payments or at the date of service. If you have any credits, a refund will be issued within 30 days.

____INSURANCE **(Please initial)**
Unfortunately, there is a great deal of confusion about dental insurance. Please remember that we do not work for any insurance company or for any PPO or HMO. **WE WORK FOR YOU**. Our treatment recommendations are based solely on our professional knowledge of what will give you the best outcome. Insurance companies' treatment recommendations are based solely on what is best for their profit margins. While we are not directly involved with any insurance company, we will do all we can to help you receive maximum benefits. For all procedures, a claim will be submitted on your behalf to your insurance company. We will follow up with the insurance company and re-bill if necessary. However, if we do not get paid in 45 days from the date of service, the balance will be your responsibility. At this time, we may ask for your help to call your insurance company to help resolve any outstanding issues. Our staff members work hard to help patients maximize their benefits from their insurance company.

____CANCELLATIONS **(Please initial)**
We understand that on occasion cancellations are necessary, particularly due to illness. However, please remember that your appointment time is reserved exclusively for you, and without adequate time to fill the broken appointment, the operatory is empty. Therefore, **if we are unable to have two full business days' notice of cancellation, there will be an overhead charge of $50 per hour for each broken cleaning appointment and $100 per hour for each procedure appointment**. The 48 hours will allow us to reschedule this appointment with someone else. We would much prefer never to make that charge, so we will schedule a time that is most convenient for you. We do understand life happens, and things might change. We only ask for open and honest communication regarding those changes.

____X-RAYS/PHOTOGRAPHY **(Please initial)**
Your initial visit will consist of a comprehensive oral evaluation and a full-mouth set of x-rays AND photos. (FMX). Insurance plans may not pay for the FMX. If your insurance denies all or part of the x-rays, you are responsible for the difference. X-rays are necessary in the diagnosis and treatment of patients. Refusal to allow necessary x-rays to be taken may result in the doctor refusing to diagnose or perform treatment until the needed x-rays are obtained. Photos may be taken to properly document your case. We are striving for the best, and photography allows us to continue improving and help others learn. Documented cases may be used in the future for learning purposes or presentations. No personal information will be included.

I have read and understand the office and cancellation fee policies.

_____
Print Name

_____ _____
Signature of Patient or Guardian Date

Thanks again for choosing Accelerated Dental!