DENTAL TREATMENT CONSENT FORM

Patient's Name:_____

Please read and initial the items checked below and read and sign at the bottom of form

AFFINITY
Dental Group
We put our heart into it!

I have been informed of the need to have a complex dental reconstruction based on my presenting condition including, but not limited to, complex diagnostics involving impressions (molds) with dental impression materials or by scan and multiple dental radiographs, bite adjustment therapy, composite resin restorations, provisional crowns and/or bridges, and fixed crowns and/or bridges. Root canal therapies may be suggested. Extractions of unrestorable teeth may be needed. Dental implants may be used to support prosthetic therapy. Removable complete denture or removable partial denture therapy may be necessary as part of provisional or definitive treatment for my dental condition. Orthodontia and/or orthognathic surgery may be suggested. Referral to sleep specialist may be warranted. Bite splint therapy may be used as part of the diagnostic and maintenance phases of treatment, and multiple bite splints may be necessary. We may also discuss with you the health of your gum tissue and presence of any gum disease. You may need gum treatment or even gum surgery. If you are concerned with the appearance of your teeth, your dentist may suggest other types of treatment to improve the way your teeth look.
The doctor of Affinity Dental will discuss a treatment plan with you based on your condition. A few options for your treatment may be given to you. This treatment usually takes place over a period of time.

FACTS FOR CONSIDERATION

The purpose and necessity for full mouth reconstruction is to repair or replace heavily worn or broken teeth and/or missing teeth, to improve the appearance of the teeth and to restore a collapsed or decreased bite.

I UNDERSTAND THE FOLLOWINGS:

I understand that due to the complexity and nature of a complex dental rehabilitation such as mine, it is not possible for the doctor of Affinity Dental or any of the staff to reasonably and predictably set an estimated time necessary for completion; however, I understand that it is not uncommon for this type of treatment to take more than a year or phased over the course of a few years to complete; it is also likely that continued maintenance and/or future retreatment may be necessary. I understand that the fees for my treatment plan be billed for each phase of treatment, regardless of whether "standard billing practices" suggest global billing. For example, I understand that there will appear to be separate charges for provisional crowns and for definitive crowns. I understand that these fees may be higher than "a la carte" therapy due to the complexity of the case. I also understand that the original treatment plan is an estimate based on the best predictions possible, and modifications to the treatment plan and associated fees based on necessary adaptations to my clinical condition may occur during treatment and are my financial responsibility.

The procedures used in the provision of care have been fully explained to me, and I understand them. I have been told that the success of the treatment depends upon several factors under my control, such as: following recommended oral hygiene procedures; following diet, nutrition, and home care advice, cooperating in maintaining the crowns, bridges or dentures; and keeping office appointments.

I further understand that despite all estimates of the success of the treatment, there are many personal and biologic factors that cannot be predicted in advance that may affect its success and estimated costs including, but not limited to, the possible need for root canal treatment for or the extraction of natural teeth, the possibility of the fracture of porcelain, composite resin, or acrylic and the need to re-make or repair the restoration, the need to remove healthy tooth structure to accommodate a prosthesis, the possibility of sensitivity to temperature and chewing, the possibility of treatment by an adjunctive dental specialist, and the possibility of a loose fit necessitating use of dental adhesives for dentures.

I also understand that provisional, or "temporary", restorations are not definitive restorations and that "permanent" definitive restorations may need repair or replacement at any time during their use.

I understand that wear of dental materials, my periodontal health, my personal health, and the health of my musculoskeletal system may necessitate the need for extensive retreatment during my lifetime; multiple bite adjustments will likely be necessary to accommodate for biological changes.

I also understand that TMJ problems can develop or exacerbate independently of any dental therapy during treatment or in the future, which may require additional treatment.

I understand that costs of adjunctive or specialty care and future dental or medical care which exceed the original estimate for my dental treatment plan are my responsibility. I further understand that Dr. Babak Mikhak is a general dentist, not a reconstructive specialist (prosthodontist), and I am declining referral to a prosthodontist at this time.

POTENTIAL BENEFITS OF FULL MOUTH RECONSTRUCTION:

This procedure may improve your appearance. It may restore your teeth. Your mouth may be healthier.

INITIAL HER _____

DENTAL TREATMENT CONSENT FORM

AFFINITY
Dental Group
We put our heart into it!

Patient's Name:_____

KNOWN RISKS AND SIDE EFFECTS OF FULL MOUTH RECONSTRUCTION:

• Damage to nerve(s). This may include temporary or permanent pain, numbness, or weakness. This may be discovered during the procedure or later.
• Discomfort from incomplete numbing of the area.
• Discomfort or pain from the initial injection.
• Having this procedure done may affect your future treatment options. Ask your doctor.
• Incomplete relief of pain.
• Numbness.
• Pain or sensitivity in the tooth.
• The results of the procedure may not look or feel the way you or others want it to.
• You may need additional tests or treatment.
• Bone infection (osteomyelitis).
• Changes in speech. Changes in the way you pronounce words.
• Infection.
• Reaction to local anesthesia or other medicines given during or after the procedure.
• Swelling.
• Breakage of teeth or trauma to the gums.
• The device, equipment, or material used to do the procedure or implanted may not work correctly, fail or cause problems during the procedure or later. The procedure may not be completed. You may need additional treatment now or later.
• Damage to the jaw, jawbone, or nearby structures. This may be discovered during the procedure, or later.

ALTERNATIVES TO FULL MOUTH RECONSTRUCTION:

• No treatment

FOR ALL PATIENTS

I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

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. The dentist will explain all changes.

I have been given the opportunity to ask questions about full mouth reconstruction. I believe that I have sufficient information to give my consent as noted below.

CONSENT

I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have the above-mentioned treatment. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

Patient's Name: _____ Date: _____

Patient's Signature: _____

INITIAL HER _____