TREY PETTY ORAL HEALTH
Compassionate Care

Trey Petty Oral Health
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PATIENT AGREEMENT AND INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

Patient Name: _____ **Date:** _____

This Informed Consent contains important information about the general dental procedures that may be included in my treatment plan. My treatment plan is specific to me and will be based upon a thorough clinical and radiological (x-ray) examination, and the current state of my health (as reported by me to Dr. Petty or his staff).

Achieving and maintaining good oral health involves treatment of both the teeth and the gums (periodontal tissue). The longevity of my restorations (fillings/caps/bridges, etc.) and the health of my gums is dependent upon how well I take care of my overall health, and includes regular brushing, flossing, dental checkups, and cleanings.

IN ORDER THAT I AM FULLY INFORMED REGARDING THE RECOMMENDATIONS IN MY TREATMENT PLAN THAT WILL AIM TO RESTORE OR MAINTAIN MY ORAL HEALTH, IT IS IMPORTANT THAT I UNDERSTAND THE RISKS, BENEFITS AND LIMITATIONS OF MY TREATMENT CHOICES, INCLUDING THE OPTION OF NO TREATMENT.

1) NO TREATMENT: The risks include, but are not limited to: pain, infection, swelling, need for antibiotics, loss of bone holding my teeth, loss of teeth, and medical issues arising from these.

2) RESTORATIONS (FILLINGS/CAPS): Although no material can replace the strength of tooth structure, this office uses materials that maximize the strength and esthetic quality of my teeth. These restorations may be either direct (known as fillings and used for smaller cavities and/or fractures) or indirect (known as crowns/caps and used when the cavities are very large, the tooth has a root canal, and/or has a large fracture). I understand that all new dental work may need to be replaced over my lifetime, depending upon how well I maintain them and the stresses placed upon them. Normal sensitivity to temperature and/or biting can be expected after the placement of a new restoration. This should disappear within a few days. However, if I notice pain and/or swelling that worsens over time (can occur weeks to years after a restoration is placed), it may need either a root canal treatment or removal (extraction). This is due to the cavity/fracture causing irreversible changes to the nerve of my tooth (pulp), which may not have been evident before my treatment (either on the radiograph [x-ray] or clinically in my mouth).

With crowns, bridges, veneers and bonding, I understand that it might not be possible to perfectly match the colour of my natural teeth with the artificial teeth. If a temporary crown is placed, I understand it may come off and that I need to be very careful with it until the final crown is placed. I realize that the last opportunity to make changes in my new restoration (e.g. the shape, colour, size) must be done before final cementation. I also understand, that in some cases, cosmetic procedures may result in damage to the nerve of the tooth, leading to pain/ infection and future root canal treatments or loss of the tooth. This cannot always be predicted.

PLEASE TURN OVER

3) DENTAL CLEANINGS (HYGIENE / PERIODONTAL TREATMENT): Treatment of my gums may include scaling (to remove tartar/calculus), polishing (to remove plaque and stains on the surface of teeth), and fluoride treatment (to decrease the risk of future cavities). Please speak with your hygienist or dentist if you do not wish to receive fluoride treatment on your teeth.

When calculus and plaque have been present for a long time, the gum and bone around the teeth may start to recede, resulting in recession of the gums and resorption of the bone supporting the teeth. This may require numerous hygiene appointments and the possible use of local anesthetic (numbing/freezing) for proper treatment. As calculus is removed from my teeth, my teeth may become more sensitive, spacing between them may become evident, they may become mobile, or their roots may become exposed as the infected and swollen gum tissue heals and shrinks. When treating this type of infection, there is the risk of an increase in infection due to the bacteria in my mouth. When gum disease is moderate to severe, it may require treatment with antibiotics and/or a referral to a periodontal (gum) specialist. As is the case with tooth decay, periodontal (gum) disease may not be associated with pain until it becomes severe. Early treatment and regular cleanings are the best way to control and prevent periodontal (gum) disease.

4) LOCAL ANAESTHETIC (NUMBING / FREEZING): Many dental procedures require the use of local anaesthetic to numb / "freeze" the area so that I am comfortable during my treatment. There are potential risks and side effects to the administration of local anaesthetic, which include but are not limited to bruising (hematoma), racing heart (cardiac stimulation), temporary or permanent numbness / tingling (very rare) to my lip, cheek, tongue or other tissue, muscle soreness, and needle breakage (extremely rare) requiring surgical retrieval.

5) CHANGES IN MY TREATMENT PLAN: During my treatment, it may be necessary to change or add procedures that were not discovered during my initial examination. A common example of this is a deep cavity extending to the nerve (pulp) of a tooth clinically, but unfortunately not demonstrated on the radiograph (x-ray). This tooth would then require a root canal before the restoration could be completed, or may require some other treatment.

6) LIMITED MOUTH OPENING: A result of opening my mouth for an extended period of time. It may last for several days or weeks, with possible pain / clicking of the jaw joint.

7) UNUSUAL REACTIONS TO MEDICATIONS GIVEN OR PRESCRIBED: Mild to severe reactions, may occur from the anesthetics (numbing / freezing) or other medications administered, recommended or prescribed. Prescription drugs must be taken according to the instructions. Antibiotics can render oral contraceptives ineffective; women who are using oral contraceptives should use another form of birth control while taking antibiotics.

I HAVE READ THIS PATIENT AGREEMENT AND INFORMED CONSENT FOR GENERAL DENTAL TREATMENT. I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION AND I FULLY UNDERSTAND THE TERMS OF THIS AGREEMENT.

Patient/Guardian Signature:_____ Date:_____

Dentist Signature:_____ Date:_____

We would like to welcome you to Trey Petty Oral Health. Thank you for choosing our office.