Summit Dental
1805 West Dickerson, Building #2, Suite #2, Bozeman, MT 59715

GENERAL CONSENT FOR TREATMENT PERFORMED BY

William R. Samson, DDS
And Staff

I give my consent to Dr. Samson and Summit Dental Staff to perform treatment that has been recommended. **I know** that each person reacts in a different way to treatments and procedures therefore, the results cannot be certain. Any questions I have about the recommended procedure have been answered.

I have been told fully and I understand completely:

1. The treatment or procedure that my doctor plans to do.
2. What to expect from the treatment or procedure (the benefits).
3. The serious risks of this treatment or procedure. Some of these risks can happe despite all steps being taken to prevent them.
4. Other types of treatment that could be used, this includes no treatment.
5. Whether or not the treatment or procedure is uncommon.

I am aware that during the procedure, other procedures might be needed. **I give my consent** to do these procedures as needed.

I give my consent for Summit Dental to dispose of any substance removed as part of my treatment or procedure.

I give my consent to receive anesthesia and/or drugs I may need. I know that all procedures and anesthetics have risks such as stroke, heart attack, respiratory failure and death. Some other risks are tooth and nerve damage, and skin/soft tissue injury.

I know I can change my mind about the consent at any time *before* treatment.
I know that I must tell the health care staff caring for me if I change my mind.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully 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 have had the opportunity to read the form and ask questions and my questions have been answered to my satisfaction. I consent to the proposed treatment.

The following is a list of possible dental procedures that *may* be recommended:

1. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause ALLERGIC reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand that occasionally needles break and may require surgical retrieval by an oral surgeon.

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Samson to make any changes and additions as necessary.

3. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.). I understand removing a tooth does not always remove all of the infection, if present, and it may be necessary to have further treatment. **I understand the risks involved in having teeth removed, some of which are pain, broken roots left in bone, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.**

4. CROWN AND BRIDGES

I understand that sometimes it is not possible to match the color & shape of artificial teeth **exactly** with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily 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 or bridge (including shape, fit, size, and color) will be before cementation. I am aware that there is no guarantee of the longevity of my Crown or bridge. **I am also aware that when cutting teeth there is a chance that the nerve of the tooth could become injured and that possible root canal therapy would be needed before or after the crown is delivered.**

5. DENTURES AND PARTIAL DENTURES

I realize that dentures and partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture or partial denture including shape, fit, size, placement, and color will be during the try-in visit. I understand that most dentures and partial dentures may require **relining** approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. Also, after the initial phases of adjustments have been made, any further adjustments may be considered as an additional fee.

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy) which is performed by a specialist, and is an additional fee to the patient. I also understand that when my root canal is started that it needs to be completed within a month to prevent future infection. I understand that if the root canal is not completed within a specified time (one month) and infection develops that I will be charged an additional fee for treating the infection.

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Our office will treat your conditions as deemed necessary. The treatment that will be performed will consist of scaling and root planing (cleaning below the gums) in the quadrants that require such treatment based on our diagnosis. We may also prescribe you a mouth rinse to aid the reduction of the bacteria in the mouth; this will help with your home care. After the initial deep cleaning you will return in approximately 3 months for periodontal maintenance, this is not inclusive of the scaling and root planing fee. If progress is acceptable we will place you on a three to six month recare program. If progress is not acceptable, then we will recommend that you follow up with a Periodontist (gum specialist) for further treatment that may include surgery. Any questions ask the staff. **The mouth is broken down into quadrants (there are four total)-top right, bottom right, top left, bottom left. Fees are based on quadrants that need the deep cleanings from 1-4 quadrants.**