Informed Consent for Initial Examination & Cleaning

1. EXAMINATIONS AND X-RAYS
I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan based on diagnosis by Dr. Patterson. (Initials ______)

2. DRUGS, MEDICATION AND SEDATION
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking. I have informed Dr. Patterson of any known drug allergies. (Initials ______)

3. CHANGES IN TREATMENT PLAN
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, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Patterson to make changes and additions as necessary. (Initials ______)

4. TEMPRO-MANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials ______)

5. DENTAL PROPHYLAXIS (CLEANING)
I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tarter & stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gingivitis and gum disease. (Initials______)

6. DEBRIDEMENT (DETAILED CLEANING)
I understand that this type of cleaning is preventative in nature in intended for clients with gingivitis (inflamed & bleeding gums) and is for the removal of heavy build up of tarter and stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gum disease. (Initials______
7. PERIODONTAL TREATMENT (Deep Cleaning)
I understand that this type of cleaning for a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of
my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatments
include non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment
depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed by Dr. Patterson, follow a healthy diet,
avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if
it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future
adverse effect on the long-term success of dental restoration work. (Initials ______)

8. DENTAL INSURANCE BENEFITS
I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Patterson's
recommendation's for optimal dental treatment. I understand that Dr. Patty’s Dental Boutique is confirming my dental benefits and filling my
insurance for treatment as a courtesy, but submitting and receiving benefits is ultimately my responsibility. (Initials ______)

Client Signature: ____________________________ Date: ____________________________
Doctor Signature: ____________________________ Date: ____________________________