Brandon McCullough D.D.S. General Dentistry Informed Consent

Patient Name _____

I understand that I am having the following work done and authorize the treatment as indicated.

X-rays _____ Exam _____ Cleaning _____ Initials _____

1. WORK TO BE DONE- I understand that I am having the following work done: Fillings _____ Bridges _____

Crowns _____ Extractions _____ Root Canals _____ Implant _____ CTG _____ Bone Graft _____ Initials _____

2. DRUGS AND MEDICATIONS- I understand that antibiotics and other medications can cause severe allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

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 are not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist (Dr. Brandon McCullough or his associates) to make any/all changes and additions necessary, after informing me of said changes. Initials _____

4. REMOVAL OF TEETH- Alternatives to removal of teeth have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist (Dr. Brandon McCullough or his associates) to remove tooth/teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, opening into sinus, loss of feeling in my teeth, lips, tongue, and surrounding tissues (paresthesia) that can last for an indefinite period (days or months) or fractured jaw. I understand that complications may require further treatment by specialist or hospitalization. Initials _____

5. CROWNS, IMPLANT CROWNS, BRIDGES, IMPLANT BRIDGES AND CAPS- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial 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, implant crown, bridge, implant bridge or cap (including shape, fit, size and color) will be before cementation. I further understand that my gingival (gums) may be sore until healing time elapsed and that during this healing time my gingival around the tooth being capped may shrink (recession), sometimes making the tooth look longer than the natural tooth. Initials _____

6. DENTURES-COMPLETE OR PARTIAL- I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to my including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, size, fit, tooth placement and color) will be the teeth in the wax try-in visit. I understand that most dentures require relining approximately 3-12 months after initial placement. The cost for this procedure is not included in the initial dental fee. Initials _____

7. ENDODONTIC TREATMENT (ROOT CANAL)- I realize there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend 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). Initials _____

8. PERIODONTAL LOSS (TISSUE & BONE)- I understand that I may have a serious condition, causing gum and bone inflammation and/or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Initials _____

I understand that Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature Date