

EAST TAYLOR DENTAL, P.C.
OFFICE POLICY
Killian J. Horner, D.D.S.

INFORMED CONSENT FOR TREATMENT

- ❖ I hereby authorize the dentist to designate staff to take x-rays, study models, photograph's and any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of myself or my dependents dental needs. Upon such diagnosis, I understand a treatment plan will be formulated. From this treatment plan, I will be provided with an estimate of the cost of the treatment. However, I understand that this is only an ESTIMATE.
- ❖ I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- ❖ I also understand that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those originally planned. I therefore authorize and request that the doctors and staff of East Taylor Dental Associates perform such procedures as are necessary and desirable in the exercise of sound professional judgment.
- ❖ I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications. Possible complications in general dentistry includes, but are not limited to:
 - 1) Post-operative discomfort and swelling which may necessitate several days of home recuperation.
 - 2) Injury to adjacent teeth and fillings.
 - 3) Post-operative infection requiring additional treatment.
 - 4) Stretching of the corners of the mouth with resultant cracking and bruising.
 - 5) Restricted mouth opening for several days or weeks.
 - 6) Injury to the nerve underlying the teeth during anesthesia (shots) or extractions resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months or in rare instances, permanently.
 - 7) Discoloration at the injection site or in rare cases, bruising of the cheek close to the injection site.
 - 8) Exposure of the nerve while preparing the tooth for a filling or crown.
 - 9) The need for root canal therapy after restorative work (e.g. fillings, crown) resulting from deep restorations or stress caused by multiple restorations to the same tooth.
- ❖ I agree to the use of anesthetics, sedative and other medications as necessary.
- ❖ I understand that it is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatments.
- ❖ I understand that if I do not understand the proposed treatment, it is better to ask any questions I have before treatment is started.

PATIENT, PARENT, OR GUARDIAN SIGNATURE:

DATE: