HOLDBROOK PEDIATRIC DENTAL LLC

INFORMED CONSENT

Choosing among reasonable treatment alternatives is a shared responsibility of dentists and patients. In the usual case, a dentist will recommend a course of treatment. While a patient often decides to adopt the recommendation, the ultimate decision is for the patient to make. Under the law in New Jersey, a dentist is obligated to inform the a patient of various treatment options suitable for their dental problems as well as the advantages, disadvantages, risks and benefits of the various offered modalities. This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to fulfill the dentist's legal obligation to obtain informed consent.

- **WORK TO BE DONE**

  I understand that I am having the following work completed:

  - ○ Fillings
  - ○ Bridges
  - ○ Crowns
  - ○ Extractions
  - ○ Dentures/Partials
  - ○ Root Canals
  - ○ Other_____
    _____

- **DRUGS, MEDICATIONS**

  Drugs, medications or anesthesia/sedation can cause allergic and other reactions. Examples include, but are not limited to swelling, redness, itching, vomiting, diarrhea, numbness or tingling of the lip, gum, or tongue. (which in rare cases may be permanent) and also in rare cases, anaplylatic shock. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days as well as those that have been prescribed within the last 6 months but not taken, and all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by the dentist may result in continued or aggravated infection and pan and potential resistance to effective treatment. In addition, antibiotics can reduce the effectiveness of birth control pills.

Patient Initial _____ Doctor Initial_____
Date_____

Patient Initial _____ Doctor Initial_____
Date_____

- **FILLINGS**

  The most common undesirable side effects associated with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, tooth nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and very rare allergic reactions to filling materials.

Patient Initial _____ Doctor Initial_____
Date_____

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- **CROWNS, ONLAYS/INLAYS, BRIDGES, VENEERS AND BONDING**

  Sometimes, it is difficult or impossible to exactly match the color of artificial teeth or restorative materials with natural teeth. Although assistance will be provided by the dentist, it is my responsibility to request changes, if any (including, for example, shape size, fit and color). before permanent cementation. After a temporary crown has been placed, it essential to have the new crown cemented as soon as it is ready because the temporary crown is not intended to function as a permanent restoration. Failing to replace the temporary crown could lead to decay, gum disease, infections, problems with the bite and even loss
  of the tooth. Further, if there is a prolonged delay in placing the permanent crown, it may no longer properly fit.

Patient Initial____ Doctor Initial____
Date_____

Patient Initial____ Doctor Initial____
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- **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 me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color) will be the *"teeth in wax"* try-in visit. I understand that most dentures require relining approximately 3 to 12 months after initial placement. I also understand that often the best of dentures will not function as well as healthy, natural teeth.

Patient Initial____ Doctor Initial____
Date_____

Patient Initial____ Doctor Initial____
Date_____

I have discussed the treatment alternatives, risks, outcomes with the Dentist and have had all of my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in treatment plan, as detailed above.

Patient Name (Please Print) _____ **Date:** _____

Patient/Legal Guardian Signature _____ **Date:**_____