INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

•You, the patient, have the right to accept or reject dental treatment recommended by your dentist – Dr. Michael of Michael Dental Care- aka MDC. Prior to consenting treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. It is the belief of MDC that you should be informed about the treatment we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to tell of the risks that may occur in dental treatment, and other treatment choices.

•Do not consent to treatment unless/until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you follow Dr. Michael's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

•The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience in a swift manner so they can be properly addressed.

•RISKS and INCONVENINCES OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, permanent or temporary nerve numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis , object ingestion or inhalation, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects. Teeth may become sensitized to cold and hot following procedures. Teeth may require additional work after some has been completed. Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

•FACT: If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics. Certain heart conditions, heart surgeries, diabetes, immunosuppressant therapies and joint surgeries create a possibility of serious or fatal complications related to dental work. If you have a heart condition or heart murmur, surgery, or another condition your regular doctor has informed you of - advise your dentist immediately so the appropriate treatment can be rendered. Often antibiotics are recommended before dental visits. If you have a history of addiction, be aware pain killers are often required in dental treatment as part of proper care, and need to be avoided – clearly inform the dentist.

•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 unable to be discovered during examination. I approve any modification in design, materials or care, if it is felt this is for my best interest. I give my permission to the MDC to make changes, additions or deletions when necessary though I may not be able to consent to those changes ahead of time. I will be informed by MDC should this occur as soon as reasonably possible.

•RELEASE OF PROTECTED HEALTH INFORMATION: I understand that in order to receive proper care, it may be necessary to use my health care information for many purposes. These purposes include but are not limited to: obtaining insurance payment for services rendered, determining insurance benefits or the benefits payable for related services, referrals to other specialists, mail, emails, voice, text messages for appointment reminders, electronic transfer (via unsecured email or wireless) of records to and from dental providers, insurance companies or to another entity directly involved in my care. In addition, I consent that photographs and/or videos of the procedures may be shown for laboratory, teaching, publications, renumeration or research purposes. My identity will remain anonymous and not be revealed without my consent. I understand there may be a need to consult with other health care providers for the purpose of protecting my dental and general health. I authorize and allow that my health information be disclosed by MDC under these or similar circumstances.

•I authorize MDC and Staff to treat me with the following procedures if and when deemed necessary: Cleanings, Exams, X-rays, Fillings, Cosmetic Dentistry, Crowns, Bridges, Veneers, Implants and their restorations, Night guards, Tooth-whitening, Root canals, Tooth extractions, Nonsurgical gum treatments, Invisalign and Orthodontics, emergency care, diagnostics, and other treatments MDC deems necessary to benefit my oral and overall care.

•I authorize MDC and Staff to perform dental work upon me for the purpose of attempting to improve the function, health and esthetics of my mouth, teeth, bone and tissues. I understand the benefits, risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. Any questions I have asked have been answered to my complete satisfaction. I also authorize the operating Dentist and staff to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment when I am made aware of such issues.

•I understand that dentistry is not an exact science, and therefore reputable practitioners, like Dr. Michael and staff, cannot properly guarantee results. Although MDC strives for the best possible outcome in any treatment situation, I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I am authorizing. By signing I acknowledge I understand this document and agree to be bound by its terms.

•Name: ____ •Date: _________________________