DONA W. PRINCE D.D.S., F.A.G.D., P.C.
ESTHETIC DENTISTRY

Treatment Discussion for General Dental Procedures

You, the patient have the right to accept or reject dental treatment recommended to you by Dr Prince, or the hygienists. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with Dr. Prince, or the hygienists and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept the known risks and complications, no matter how slight the probability of occurrence.

It is important that you provide Dr. Prince with accurate information before, during and after treatment. It is equally important that you follow Dr. Prince'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 Dr Prince, you may increase the chances of a poor outcome.

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, advice Dr. Prince immediately so she can consult with your physician if necessary.

You, the patient, are 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 so they can be addressed by Dr. Prince.

If you are a woman an oral birth control medication, you must consider that fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if Dr. Prince prescribes, or if you art taking antibiotics.

As with all treatment, there are commonly known risks and potential complications associated with dental treatment. On the can guarantee the success of recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can occur.

Some of the more commonly known risks and complications of treatment include, but are limited to the following:

Pain, swelling, discomfort after treatment.
Infection in need of medication, follow up procedure or other treatment.
Temporary, or on rare occasions, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums and tongue along with the possible loss of taste.
Damage to adjacent teeth, restoration or gums

Possible deterioration of your condition which may result in tooth loss.
The need for replacement of restorations, implants or other appliances in the future
An altered bite in the need of adjustment
Possible injury to the jaw and related structures requiring follow-up care and treatment or consultation by a dental specialist
A root tip, fragment of instrument may be left in your body and may have to be removed at a later time if symptoms develop.
Jaw fracture
If upper teeth are treatment, there is a chance of sinus infection or opening between the mouth and sinus
Cavity resulting in infection or the need for further treatment.
Allergic reaction to a anesthetic or medication.
Need for follow-up treatment, including surgery

This Form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood and accepted each paragraph stated above. Please discuss the potential risks , complications of recommended treatment with Dr. Prince and assistants. Be certain all of your concerns have been addressed to your satisfaction by Dr. Prince and her assistants before commencing treatment.

I hereby authorize Dr. Prince to perform the dental restorations and treatments explained to me. I understand that this is only and estimate and subject to modification depending on unforeseen or diagnosable circumstances.

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PATIENT SIGNATURE DATE WITNESS DATE

_____ _____

PRINT PATIENT NAME PARENT/LEGAL GUARDIAN DATE