The Bright Bite

PATIENT CONSENT FORM

Patient's Name:_____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ TREATMENT

I understand that I may have the following dental treatment performed: Treatment of Periodontal Disease or other work deemed necessary

_____ DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea, and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ PERIODONTAL DISEASE

Periodontal disease can cause gum and bone inflammation and/or loss and, without treatment, almost always lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____ CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedure because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding my dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____

Patient's or Gaurdian's Siganture Date

_____

Doctor's Siganture Date

_____

Witenss' Siganture Date