Informed Consent for Initial Examination & Cleaning

Patient Name: _____ D.O. B: ____/_____/_____

1. **EXAMINATIONS AND X-RAYS** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand Dr. Pham will perform an examination, resulting in her diagnosis and a treatment plan. (Initials _____)

2. **DRUGS, MEDICATION AND SEDATION** I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been prescribed to me for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking. I have informed Dr. Pham of any known drug allergies. (Initials _____)

3. **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 were not discovered during examination, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Pham to make changes and additions as necessary. (Initials _____)

4. **TEMPRO-MANDIBULAR JOINT DYSFUNCTION (TMD**) I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials _____)

5. **DENTAL PROPHYLAXIS (CLEANING)** I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tarter & stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gingivitis and gum disease.

(Initials_____)

6. **DEBRIDEMENT (DETAILED CLEANING)** I understand that this type of cleaning is preventative in nature and intended for clients with gingivitis (inflamed & bleeding gums) and is for the removal of heavy buildup of tarter and stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gum disease. (Initials_____)

7. **PERIODONTAL TREATMENT (Deep Cleaning**) I understand that this type of cleaning is for a serious condition causing gum inflammation and/or bone loss, which can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatments include non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed by Dr. Pham, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work. (Initials _____)

8. **DENTAL INSURANCE BENEFITS** I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Patterson's recommendation's for optimal dental treatment. I understand that SmileSpot is confirming my dental benefits and filing my insurance claims for treatment as a courtesy, but submitting and receiving benefits is ultimately my responsibility. (Initials _____)

9. **ORAL CANCER SCREENING WITH ADJUNCTIVE** DEVICE Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and probably save your life. I understand that I may be responsible for a portion of the cost of this screening.

(Initials _____)

Patient Name (Printed) _____

Patient Signature: _____ Date: _____

David Pham, D.D.S. _____ Date: _____