East Valley Community Health Center, Inc. pt._____

Informed Consent

All patients complete as needed:

1. EXAMINATION AND X-RAYS
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials_____)
2. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
   I understand that symptoms of 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, and the cost of which is my responsibility. (Initials_____)
3. DRUGS, MEDICATION AND SEDATION
   I have been informed and understand that local anesthetics, 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). I understand that antibiotics can reduce the effectiveness of oral contraceptives. I understand that I may receive a **local anesthetic and/or other medication.** Anesthetizing agents are infiltrated into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. **Risks include, but are not limited to:** It is normal for the numbness tc take time to wear off after treatment, usually two or three hours. However, it can take longer and rarely the numbness is permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue or lip biting can occur. (Initials _____)

   For All Female Patients: Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the dentist if she could be or is pregnant. Anesthetics, medications and drugs absorbed in the mother's milk may temporarily affect the behavior of the nursing baby. In either case, the anesthesia and treatment may be postponed. (Initials_____)
4. FILLINGS
   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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays. I understand that sensitivity is a common after effect of a newly placed filling. (Initials_____)
5. DENTURES – COMPLETE OR PARTIAL
   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)
6. CLEANING
   I understand that complications resulting from dental cleaning procedures (teeth cleaning and topical fluoride treatments) include, but are not limited to the following: bleeding, discomfort, infection, sensitivity of teeth due to removal of deposits on teeth, soft tissue reaction to fluoride treatment to include redness of tissues, nausea if swallowed and temporary sloughing of mucosal tissues, and removal of loose or broken restorations (fillings) or crowns. (Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I further 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. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature_____ **Date**_____

Witness_____ **Date**_____