PACHECO-MEDINA
DENTAL CORPORATION

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INFORMED CONSENT FORM

PATIENT NAME:_____ DATE____/____/_____

1. WORK TO BE DONE
   I understand that I am having the following work done: Fillings ___ Bridges ___ Crowns ___Extractions ___
   Impacted teeth removed ___ Root Canals ___ Dentures ___ Partials ___Periodontics ___ Cleaning ___ Premed ___
   Pulpotomy ___ Space Maintainer ___Pedo-Partial ___ Other ___
2. MEDICATIONS AND DRUGS
   I 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).
3. CHANGES IN TREATMENT PLAN
   I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary. (initials) _____
4. REMOVAL OF TEETH
   Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and authorize the Dentist to remove the following teeth. _____.
   I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.
5. ANESTHESIA
   I realize the risks involved in receiving an anesthetic, some of which are: upset stomach, dizziness, vomiting, and adverse reactions to drugs causing cardiac arrest and/or miscarriage.
6. CROWNS, BRIDGES, AND CAPS
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns that may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered.
7. DENTURES (COMPLETE OR PARTIAL)
   I realize that full or partial dentures are artificial constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, possible breakage, and relining due to tissue change.
8. ROOT CANALS
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment.
9. PERIODONTAL LOSS (TISSUE AND BONE)
   I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other complications. The alternative plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extractions. (initials) _____
10. ALTERNATE MATERIALS
    I have been advised by the Dentist that he silver amalgam restoration is an acceptable procedure according to ADA guidelines. The advantages of alternate materials have been explained to me. (initials) ____

I hereby request and authorize the Dentist and their staff, to perform dental work upon me for the purpose of attempting to improve the appearance, function, and health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the treatment to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment, which I have herein requested and authorized. I also understand that it is my responsibility to inform the Dentist if I am having problems during or following treatment so as to allow him/her to help minimize any problem. (initials) _____

Alternative and possible untoward reactions have been explained to me in detail and clearly. Complications such as infection, hemorrhage, bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during, or after surgery, numbness or itching of the tongue, lip, teeth, or other tissues. (initials) _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THE EXPLANATIONS THEREIN REFERRED WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature _____ Relationship _____ Date ___/___/_____