

INFORMED CONSENT FOR ROUTINE PREVENTITIVE DENTAL CARE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The above mentioned patients is schedule today for routine preventative dental care. This may include routine x-rays, cleaning, exam, fluoride and dental sealants if determined to be needed.

You the patient have the right to accept or reject dental treatment recommended by your dentist. 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.

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

It is very important that you tell your dentist if you have any changes in your medical history. Certain conditions may create a risk of serious or fatal complications and the dentist may need to consult with your physician before any treatment is performed.

The patient is 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 your dentist.

Dental Prophylaxis (Cleaning)

- A dental cleaning involves scaling, flossing, and polishing all of your teeth by the dentist or dental hygienist to remove, plaque, calculus, and extrinsic staining. As a result, teeth and gums may become sensitive, teeth may become loose, gums may bleed, fillings or other restorative work may become loose or dislodged completely. Dental polishers contain mints and other additives that you may be allergic to, so it is very important that you complete a detailed health history form and list any known allergies. Topical anesthetics are sometimes used to help make cleanings more comfortable.

\_\_\_\_ (initial)

Dental X-Rays

- Dental x-rays are a very important tool that dentists need in order to properly diagnose your overall oral health. X-rays help us determine the proper type of cleaning based on bone levels and calculus detection. X-rays help us diagnose decay (cavities) in teeth and infections caused by un-healthy teeth or gums. Without x-rays Dr. Allyson will not be able to perform optimal care therefore may choose to not perform any treatment. Dental x-rays at times may be uncomfortable but we will do our absolute best to make it an easy procedure. **Please let us know if you are pregnant or trying to get pregnant.**

\_\_\_\_ (initial)

Dental Sealants

- Dental sealants are coatings that are placed on the chewing surfaces of teeth to seal pits and fissures where plaque, food, and bacteria usually become trapped. These are usually completed on children up to the age of 18. The surface is isolated to ensure that it is not contaminated with saliva and is cleaned thoroughly, dried, and etched with a phosphoric acid solution and then the sealant material is applied. These help prevent cavities in conjunction with proper oral hygiene. We advise patients to avoid hard and sticky foods and ice chewing because these actions may cause sealants to dislodge. **Please let us know if you do not want you or your child to have this procedure done.**

\_\_\_\_ (initial)

Fluoride treatment

- Fluoride is a very beneficial treatment that is applied topically to help reduce the incidence of caries. Fluoride when ingested in large quantities can cause an upset stomach. We use the minimum amount necessary. It is important to follow the post op instructions, based on the fluoride treatment given, in order to benefit from the procedure. **Please let us know if you do not want you or your child to have this procedure done.**

\_\_\_\_ (initial)

Patient/Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship (If patient is a minor): \_\_\_\_\_

Witness: (Signature): \_\_\_\_\_