Smiles OF GRAND RIVER

(734) 707-8764
55840 Grand River Ave. Ste 350
Lyon Township, MI 48165

Consent for Dental Treatment

Patient's name:_____Date:_____

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

_____ 1. TREATMENT
I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Implants, Treatment of periodontal disease, Dental risk assessments or other work deemed necessary.

_____ 2. 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, vomiting, or more severe allergic reactions. I have informed Dr. Shaheen of my known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____3. RISKS OF ANESTHESIA
I understand that pain, bruising, and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial structures can sometimes occur with "shots". The vast majority of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____4. CROWNS, BRIDGES, INLAYS, AND ONLAYS
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further un- derstand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify Dr. Shaheen of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my respon- sibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications or delays arise during treatment, and any costs thus incurred are my responsibility.

_____5. DENTURES
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, that taste of foods may be altered, and that dentures are not "permanent". I also understand that, while I no longer suffer from dental de- cay or periodontal infection as all of my teeth have been removed, I could experience denture related problems such as; shrinking of the gums, poor chewing ability, altered speech, reduced taste, and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time. A small number of these patients never adapt to dentures. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for a number of days. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is re- quired due to my delay, additional fees may be incurred.

_____6. FILLINGS
I understand that a more extensive restoration than originally planned, or possible root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature or biting pressure may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns at a later date.

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_____7. EXTRACTIONS

Alternatives to tooth removal may include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of the bone, bone necrosis, and loss of feeling in my lip or other facial areas such as cheeks, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw if the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____8. PERIODONTAL DISEASE

Periodontal disease is a serious condition leading to gum and bone infection and/or loss and may lead to loss of perma- nent teeth. There are currently many medical risks associated with untreated periodontal disease including stroke, heart disease, diabetes, low birth weight babies, and possibly dementia (Alzheimer's disease). I understand that possible treat- ment plans have been explained to me. These plans can include scaling and root planning (deep cleanings), gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal dis- ease treatment depends on my continuing meticulous home care and following Dr. Shaheen instruction, including strict observance of periodontal maintenance appointments. I understand that care by a specialist may be necessary.

_____9. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add or eliminate procedures because of conditions discovered during treatment that were not evident during examination. I authorize Dr. Shaheen to use professional judg- ment to provide appropriate care. I acknowledge that Dr. Shaheen will make every attempt to quickly notify me of changes to my plan as they become evident. I understand that dentistry, like all medical specialties, 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 dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending on 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 Dr. Shaheen, and I certify that I understand English. 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 dental treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient or Guardian's Signature Date

_____ _____

Doctor's Signature Date

_____ _____

Witness' Signature Date