Halifax Plantation Dental Spa
Jennifer L. Fraser D.M.D.

REQUEST AND CONSENT FOR DENTAL TREATMENT

Patient name_____

Legal Guardian (if patient is under 18 yrs of age) _____

I request **Jennifer L. Fraser D.M.D.**, assistants and dental hygienists to perform the following treatment/procedures:

* FOR ALL NEW PATIENTS: Oral evaluations, prophylaxis/cleaning, radiographs.

* I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the doctor.

* I have fully disclosed all health problems, including but not limited to: Heart conditions, high/low blood pressure, diabetes, need for antibiotics prior to dental treatment (due to prosthetic valves, joints or heart conditions), medications taken/prescribed, bleeding problems, and allergies. If you are receiving dental treatment other than an exam, dental cleaning and radiographs, please read and initial beside the Description of Treatment/Procedure(s):

Scaling and Root Planing _____
Extraction of Tooth _____
Root Canal Therapy _____
Fillings, Bridges, Crowns _____
Complete or Partial Dentures _____

* For Oral Surgery: The extraction of a tooth is an irreversible process and whether routine or difficult, it is a surgical procedure. In any surgery, there are some risks. These risks include, but not limited to, the possibility of pain or discomfort during and after the following treatment, swelling, infection, bruising, dry socket (due to dislodged blood clot), bleeding, injury to adjacent teeth (especially with large fillings, decay or crowns),and surrounding tissue, TMJ disorder, limited jaw opening, displacement of a tooth or portion thereof into the sinus (especially with upper back teeth), or other anatomic location requiring additional surgery (and possible referral to Oral Surgeon) to close the opening or recover the tooth structure, temporary or permanent numbness, jaw fracture and allergic reactions. In addition, the decision to leave a small piece of root in the jaw when its removal would require extensive surgery may be necessary. To avoid injury to vital structures such as nerve or the sinus, small root tips may be left in place. Sharp ridges, or bone splinters may form later at the edge of the socket and may require another surgery or smooth or remove. The usual and most frequent risks and complications occurring from the planned treatment have been explained to me and by signing this form; I consent to the extraction of the above tooth/teeth.

* For Dentures and Partial Dentures: I realize that full or partial dentures are artificial and the problems of wearing these appliances have been explained to me (including, but not limited to, looseness, soreness, and possible breakage). I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color of the teeth); will be the "teeth in wax" try-in visit. I understand the appliance may need to be relined 3-15 months after fabrication and the cost for this is not included in the initial denture. There may be additional charges for denture/partial adjustments in the future.

* For Crown and Bridges: I understand it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I will be wearing temporary crowns and will ensure that they are kept on the tooth until the definite crown/bridge is cemented. I will verify the shape, color and size at the first appointment as the crown will be ready to cement at the following appointment. Endodontic procedures (root canals) are sometimes necessary after the preparation for the crown; root canals are a separate procedure and you may need to see a specialist if a root canal is needed. For implant crowns, we are not responsible for the successful placement and guarantee of the implant as we did not perform the implant placement.

* For Endodontic Treatment (Root Canal): I realize there is no guarantee that root canal treatment will save my tooth, and that a complication can occur from the treatment that may necessitate the extraction of the tooth. Occasionally metal objects are cemented in the tooth or extend through the root, which may/may not necessarily affect the success of the treatment. I understand there is considerable risk of instrument separation during root canal treatment in which referral to an Endodontist may be necessary to evaluate the situation, complete root canal treatment and/or perform surgical procedures to increase the root canal success. I understand that occasionally that additional surgical procedures may be necessary following root canal treatment, root canals may have to be retreated, referral to an Endodontist (Ex: complicated root canal anatomy, inability to locate canals, calcified canals) may be necessary. If a tooth fracture is present, it may not be visually detected but may lead to the loss of the tooth, even after a root canal is performed.

* Children: Should at anytime a child/dependent, become uncooperative during treatment with movement of the head, arms and/or legs, it may be necessary to terminate treatment. If a decision is made to terminate care, the current procedure being performed will be brought to a logical closure. Logical closure requires the cooperation of the patient in order to prevent pain and infection that can result from open teeth. During disruptive behavior incidents, it may be necessary for the assistant(s) to hold the patients hands, stabilize the head, and/or control leg movement in order to close a tooth. A bite block may be necessary to maintain mouth opening.

* During any course of treatment, complications may arise that may necessitate additional procedures or after the propose course of treatment. Such complications may include, but are not limited to, the need for a root canal or extraction. I acknowledge the practice of dentistry is not an exact science and offers no guarantees. When administering anesthetic, there is a rare but unavoidable risk of possible nerve damage, paralysis, and/or dysesthesia. These complications may be temporary or permanent.

Signature of person consenting to treatment: I have had sufficient opportunity to discuss the treatment plan, the benefits to be reasonable expected from this treatment, as well as the alternative approaches, including no treatment. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed. I confirm I have read this form or it was read to me.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible to payment of all services rendered on my or my dependants' behalf.

Patient or Guardian Signature_____

Print Name_____

Relationship_____

Dentist Signature_____Date_____