Harold Perlaza, D.D.S
Cosmetic Dental Studio
Where Smiles Change Everyday!®

We would like to welcome you to our office. Our dental practice is committed to the highest level of care and safety for our patients, our families and our selves. We meet and exceed the standard of infection control mandated by OSHA, The Center for Disease Control and the American Dental Association. We employ "state of the art" heat sterilization of all instruments and drills, and the use of disposable items whenever possible; i.e., needles anesthetic cartridges, suction tips, towels, cups, etc.

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and should give your consent before starting treatment. The purpose of this form is to advise you of risks that may occur in dental treatment and other treatment choices.

RISKS OF DENTAL PROCEDURES IN GENERAL: Include, but are not limited to, complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics and injections. These complications include pain, infections, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vain) reaction to injection, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain in the ear, neck, and head, nausea, vomiting, allergic reaction, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs.)

We will take responsible safeguards, consistent with HIPPA privacy standards (see attached HIPPA Notice of Privacy Act), to protect patient health information, without compromising needed accessibility and use of information for treatment, payment, and internal operations. Dental records will be maintained in cabinets located in an area that is not readily accessible to the public or unauthorized persons. Only those persons authorized may remove dental records. All dental records that are removed will be returned promptly fallowing authorized use. Persons who violate this policy may be subject to remedial action.

PLEASE SIGN AND DATE EVERYTHING THAT IS MARKED.

General Dentistry Informed Consent

Patient_____

1. **GENERAL**

I understand that antibiotics, analgesics, local anesthetic and other medications can cause allergic and other reactions causing redness and swelling of tissues, numbness of indefinite duration, pain, itching, vomiting, and/or anaphylactic shock. I understand that antibiotics can interfere with the effectiveness of oral contraceptives. I understand that administration of local anesthetic or exertion of the jaw during the dental procedure can cause pain and/or restricted movement in the temporomandibular joint and surrounding muscles.

Initials/Date_____/_____

2. **CHANGES IN TREATMENT PLAN**

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: for example, root canal therapy following routine restorative procedures or crowns. Therefore fees can only be estimates and are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials/Date_____/_____

3. **CROWNS, BRIDGES, INLAYS AND ONLAYS**

Conditions that require crowns to be made may also require root canals for their resolution, which sometimes becomes apparent only after the crown has been placed. I understand that I may be wearing temporary crowns or permanent crowns with temporary cement that may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are permanently cemented. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before permanent cementation.

Initials/Date_____/_____

4. **ENDODONTIC TREATMENT (ROOT CANAL)**

Root canal therapy usually takes several appointments for completion. I understand that I must return for all appointments to complete treatment. 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 root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that as a rule a crown will be necessary in order to prevent the tooth from fracturing. I understand that the tooth may be lost in spite of all effort to save it.

Initials/Date_____/_____

5. **PERIODONTAL LOSS (TISSUE AND BONE) ROOT PLANING**

I understand that I have a serious condition, causing gum and bone inflammation. If left untreated, further bone loss and tooth loss will occur. Alternative treatment plans have been explained to me, including gum surgery and/or extractions. This non-surgical procedure will remove plaque and calculus deposits, which are causing the irritation of my gums and bone. I understand that I must return for reevaluation and periodontal maintenance cleanings every 3-4 months, sometimes even sooner only then Dr. Perlaza will be able to determine if further treatment is needed.

Initials/Date_____/_____

6. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. I understand removing teeth does not always remove all the 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, bone fracture, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time. I understand I may need further treatment by the specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initials/Date_____/_____

7. **FILLINGS**

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 filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling.

Initials/Date_____/_____

8. **DENTURES**

I understand that the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. An immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures, and that failure to keep my delivery appointment may result in poorly-dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

Initials/Date_____/_____

9. **APPOINTMENT POLICY**

If you are unable to make the appointment that you have scheduled with us, please notify us **at least 48** hours in advance, or a charge of $75 per hour will be added to your account. Your cooperation will be greatly appreciated.

Initials/Date_____/_____

10. **PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIAL FACT SHEET**

I, _____, acknowledge that I have received from Harold Perlaza, D.D.S. Studio a copy of the Dental Materials fact sheet dated October 2001.

Initials/Date_____/_____

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

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient (parent or legal if minor)

_____ Date_____

Signature of Doctor

_____Date_____