Office of Sally Kashani DDS Consent for General Dentistry

Please read consent for first appointment

***1. EXAMINATION AND X-RAYS _____**
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

***2. DRUGS, MEDICATION, LOCAL ANESTHETIC _____**
I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

Local anesthetics may be used for dental treatment. Some of the more common complications that may occur secondary to the administration of local anesthetic in dentistry include swelling and bruising, and soreness of injection spot. Some of the rare complications can include permanent numbness or abnormal sensation, as well as death.

Other medications used for sedation may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effects treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

***3. PERIODONTAL TREATMENT _____**
I understand that there are different forms of periodontal treatment. Depending on the condition of my gums and bone the doctor may do a simple or deep cleaning. This may be followed by a polishing of the teeth.
I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

***4. 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

***5. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD) _____**
I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

Patient's Signature: _____ **Date**_____

Doctor : _____