Smile Brite Dental-Naushil Desai D.M.D., INC.
600 South Euclid Street Anaheim, CA 92802

General Dentistry Informed Consent

1. *WORK TO BE DONE

I understand that as a new patient and for successive recall appointments, I give my consent for oral examinations, X-Rays and for a prophylaxis cleaning (as necessary). Initials

2. *DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions, causing redness and swelling of tissues, pain, itching, vomiting, diarrhea, and/or anaphylactic shock. I have discussed any allergies and/or sensitivities I have to medication with the Dentist, as well as any medical conditions and current medications which may contribute to any potential reaction to medications. In addition, anesthetics given may cause temporary or permanent paresthesia (numbness).

Initials

3. *CHANGES IN TREATMENT PLAN

I understand that during treatment, it may become necessary to change (add/remove) procedures, due to conditions found while working on teeth that were not discovered during examination. I give permission to the Dentist to make any and all changes to the course of treatment as necessary. Initials

4. REMOVAL OF TEETH

Alternatives to tooth (teeth) removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.), and I authorize the Dentist to remove a tooth/teeth and any others necessary for in paragraph #3. 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 risk involved in having teeth removed, some of which are: pain, swelling, fractured jaw, and spread of infection, dry socket, loss of feeling in my teeth, tongue and surrounding tissue (paresthesia) that may last for an indefinite period of time. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initials

5. CROWNS, BRIDGES, AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color,) will be before cementation. 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, bride or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Initials

6. ENDODONTIC TREATMENT (ROOT CANAL)

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 the 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 further understand that endodontic treatment must be followed by some type of restorative treatment, such as a post and crown or a filling. I understand that this treatment should be done within 2-3 weeks of the root canal treatment. Any delay on my part in restoration of the tooth will cause the tooth to become further damaged, and eventually become reinfected or break, which may result in loss of the tooth.

Initials

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that periodontal disease a serious condition, causing gum and bone inflammation or loss and may lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials

8. FILLINGS

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after affect of a newly placed filling. I understand that in some cases, root canal treatment may be necessary, if sensitivity persists.

Initials

* Required for all new patients

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extraction) may be painful; the denture may require considerable adjusting and several relines. A permanent reline will be necessary. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 10 days after the initial scheduled delivery, there will be additional charges.

_____Initials

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot correctly guarantee results.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or any costs that may be incurred in order to satisfy this obligation.

I understand that billing to my dental and/or medical insurance company/companies is a courtesy on the part of Naushil Desai D.M.D., INC. staff. I further understand that regardless of various dental/medical insurance policies, I am responsible for payment in full for my treatment to Naushil Desai D.M.D., INC. I also agree to assist the staff at Naushil Desai D.M.D., INC. in attaining payment from my insurance company, and will promptly and accurately respond to any and all correspondences to ensure payment in full.

_____ _____

*Signature of Patient Date

_____ _____

Signature of Doctor Date

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I, _____, have been given a copy of this office's Notice of Privacy Practices.

Patient Name

_____

Printed Name of Patient

_____

Signature of Patient/Legal Guardian **Date**

FOR OFFICE USE ONLY

- ☐ **Individual Refused to Sign**
- ☐ **Emergency Situation Prevented Signature of Acknowledgement**
- ☐ **Communication Barriers Prohibited Obtaining the Acknowledgement**
- ☐ **Other** _____

* Required for all new patients