Extraction Consent

Parkside Family Dental

Informed Consent Tooth Removal

I understand that the extraction of tooth and/or teeth has been recommended by my dentist. I have had alternative treatment (if any) explained to me, as well as the consequences of doing nothing about my dental conditions. I understand that non-treatment may result in, but not be limited to: infection, swelling, pain, periodontal disease, malocclusion (damage to the way the teeth hit together) and systemic disease.

I understand that there are risks associated with any dental and anesthetic procedure.

These include, but are not limited to:

Post-operative infection

Swelling, bruising, and pain

Damage to adjacent teeth or fillings

Bleeding requiring more treatment

Drug reactions and side effects

Possibility of a small fragment of root or bone being left in the jaw when it's removal is not appropriate. Such fragments may work their way partially out of the tissue and need treatment at a later date

Damage to sinuses requiring additional treatment or surgical repair at a later date

Fracture or dislocation of the jaw

Damage to nerves resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas

Delayed healing (dry socket) necessitating post-operative care

I understand the recommended treatment, the fee(s) involved, the risks of treatment, any alternatives and risks of these alternatives, including the consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

Signature: _____

Date: _____

SRP Consent

Informed Consent

Periodontal Scaling and Root Planing

I understand that I have periodontal (gum and bone) disease and that the following quadrant(s) will be treated with scaling and root planing: UR LR UL LL. The disease process has been explained to me and I understand that it is caused by bacterial toxins (poisons) and my host response to these toxins.

I realize that this disease may be painless and symptomless, but that usually symptoms such as bleeding, swelling or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity and soreness may be noticed. Treatment of periodontal disease may include periodontal scaling and root planing, either as a therapeutic procedure, or preliminary to more extensive treatment.

Periodontal scaling and root planing involves the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root surface) and diseased tissue from the inner lining of the crevice surrounding the teeth. The purpose of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my own efforts with home care are just as important as my professional treatment.

Consequences of doing nothing about my periodontal condition may be, but are not limited to:

- **Worsening of the disease with increased bone loss and possible eventual tooth loss**
- **Increased infection, systemic problems, bleeding, pain and soreness**

Treatment risks may be, but are not limited to:

- **Increased recession of gum tissue and exposure of root surfaces (as tissue heals, swelling decreases).**
- **Increased sensitivity to hot, cold, or sweets. This may require further treatment, may fade with time, or may persist no matter what is done.**
- **Exposed roots may acquire stain more readily.**
- **Food may collect between teeth. Proper cleaning techniques will be explained in detail.**
- **If teeth were loose prior to the procedure, they may seem looser immediately after. Usually after healing, teeth "tighten".**
- **Some pain, swelling or bruising may be experienced after treatment.**

I understand the recommended treatment; the risks of such treatment and any alternative treatment and risks have been explained to me. I understand the fee(s) involved in the treatment as well as consequences of doing nothing.

Signature: _____

Date: _____

Refusal of Periodontal Treatment

Parkside Family Dental

Refusal of Periodontal Treatment

I have been advised and understand on this date that I have periodontal disease that may cause gum and bone inflammation or loss, and that it can lead to loss of my teeth. I have been informed that periodontal pockets and/or bleeding points are indicatively of disease. I have been shown pockets and/or bleeding in my mouth. The severity of my condition is slight/moderate/advanced. I have been informed that I have pocket depths as follows:

Depth of Infected Pockets	Detail
☐ Early Periodontitis (4mm)	
☐ Moderate Periodontitis (5mm)	
☐ Advanced Periodontitis (6mm)	
☐ Other	

Various Treatment options for this condition have been explained to me, including:

- ☐ Non-surgical therapy
- ☐ 3 month maintenance visits
- ☐ Locally applied antibiotics
- ☐ Recommendation for gum surgery
- ☐ Extraction & replacement
- ☐ Other

I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I am electing to refuse treatment and agree to release and hold harmless this office and the undersigned dentist from any liability for adverse effects of my decision. I understand that periodontal disease is progressive and that failure to treat the disease as recommended may result in eventual tooth/bone loss and acute illness.

Signature:

Date:

Bone Grafting & Barrier Member

Parkside Family Dental
Bone Grafting and Barrier Membrane Consent Form

I understand that bone grafting and barrier membrane procedures include inherent risks such as hut not limited to the following:

1. **Pain. Some discomfort is inherent in any oral surgery procedure. Grafting with materials that do not have to be harvested from your body is less painful because they do not require a donor site surgery.**
2. **Infection. No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.**
3. **Bleeding, bruising, and swelling. Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.**
4. **Loss of all or part of the graft. Success with bone and membrane grafting is high. Nevertheless, it is possible that the graft could fail. A block bone graft taken from somewhere else in your mouth may not adhere or could become infected. Despite meticulous surgery, particulate bone graft material can migrate out of the surgery site and be lost. A membrane graft could start to dislodge, if so, the doctor should he notified. Your compliance is essential to assure success.**
5. **Types of graft material. Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by different means to be free from contaminants. Signing this consent form gives your approval for the doctor to use such materials according to his knowledge and clinical judgment for your situation.**
6. **Injury to nerves. This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur, may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.**
7. **Sinus involvement. In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus. Occasionally, with extractions and/or grafting near the sinus, the sinus can become involved. If this happens, you will need to take special medications. Should sinus penetration occur, it may be necessary to later have the sinus surgically closed.**
8. **It is your responsibility to seek attention should any undue circumstances occur post-operatively and you should diligently follow any pre-operative and post-operative instructions.**

Informed Consent: As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Bogdan Graboviy to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Signature: _____

Date: _____

Implant Placement

Parkside Family Dental
Implant Placement

I understand that implant surgery involves the placement of metal anchors into the jaw bone. The length and thickness of the implant depends on t.'ie amount of supporting bone available in the jaw. The number of implants placed is determined by the number of teeth to be replaced, the amount of supporting bone available, and the amount of anchorage and nature of the intended fixed or removable prosthesis (crowns, fixed bridges or removable full or partial dentures).

I have been informed of the treatment, including alternatives. Some of the possible risks and complications of implant surgery include but are not limited to:

- **Reactions or side effects to drugs used during or after surgery**
- **Damage to nearby teeth and fillings**
- **Infection**
- **Swelling, bruising and/or pain or sub lingual hematoma, a rare, serious swelling of floor of the mouth**
- **Post-operative bleeding requiring treatment**
- **Delayed or inadequate healing, or post-operative infection requiring removal of the implant. A new implant may or may not be possible in a later surgical procedure.**
- **Possibility of involvement of the sinus, nerves, or nasal cavity which may require removal of the implant.**
- **Tingling or numbness of the lip, chin, face, tongue, and gums. These symptoms may be temporary or permanent.**
- **Rejection or poor toleration to the implant necessitating removal.**
- **Difference in the appearance of the prosthetic replacement (false teeth) from the original teeth.**

I understand that one alternative to treatment is to do nothing. Some of the risks of doing nothing might be, but are not limited to:

- **Loss of bone and gum tissue**
- **Inflammation, infection, and sensitivity**
- **Jaw joint problems, and/or sore spots from appliances**
- **Headaches and referred pain to other areas of the body**

I have elected to undergo implant surgery. I understand that there are no guarantees that the proposed treatment will be successful or that I will be completely or partially satisfied. I understand the treatment, the risks of such treatment, any alternatives have been explained to me and the risks of these alternatives, the consequences of doing nothing about my condition, and the fee(s) involved.

Signature: _____

Date: _____

Surgical Placement Implant

Parkside Family Dental
Surgical Procedure

I have been made aware of my condition requiring a surgical remedy in the opinion of my dentist. I am aware that the practice of dentistry and dental surgery is not an exact science, and no guarantees have been made to me concerning the results of the procedure. I understand and authorize my dentist to select alternative methods of treatment based on my condition as disclosed during the procedures authorized by my signature on this form, including conditions which were unknown at the time surgery or dental procedures were begun.

I understand that there are substantial risks and consequences that may be associated with any surgical, dental, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed. I realize the following possibilities exist, however infrequent or rare. These include but are not limited to:

- **Excessive bleeding requiring blood transfusion with its risks, or re-operating to control blood loss**
- **Blood clots anywhere in the body**
- **Infection**
- **Allergic reactions to medications or anesthesia**
- **Collection of blood or fluid requiring later drainage**
- **Injury to or infection of other organs, nerves or blood vessels**
- **Possible temporary or permanent numbness of the lip, tongue, face or other areas**
- **Fracture or dislocation of the jaw**
- **Perforation of the sinus area**
- **Entrance into the maxillary sinus to remove fragmented tooth or bone**
- **Pain, swelling, and bruising**
- **Complications requiring hospitalization**

I understand the recommended treatment, the risks of such treatment, any alternatives have been explained to me and the risks of these alternatives, the consequences of doing nothing about my condition, and the fee(s) involved.

Signature: _____

Date: _____

I understand that I have conditions requiring dental treatment in the opinion of my dentist:

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing.

CONSENT FOR TREATMENT

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I confirm that I understand this form and the information contained therein.

Signature: _____

Date: _____

INSURANCE ESTIMATES ARE ESTIMATES ONLY AND NOT A GUARANTEE OF PAYMENT

Treatment fees are ESTIMATES only, are valid for 30 days from date shown above, and are subject to revision. Treatment will be altered if your dental needs change. You will be notified if there are changes in treatment.

I have reviewed the above treatment plan estimate and I understand that I am responsible for the total treatment. Any fee(s) involved have also been explained.

I understand that my insurance is a contract between me and my insurance. Our office will file your insurance as a courtesy to you. If your insurance has not paid your claim within 30 days it will become your responsibility.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider.

I confirm that I understand this form and the information contained therein.

Signature: _____

Date: _____

Frenectomy Consent

Parkside Family Dental
PATIENT'S CONSENT FOR FRENECTOMY

DIAGNOSIS: I have been informed of the presence of a frenum that might be exceptionally short, thick, tight, or may extend too far down along the gum. When a frenum is positioned in such a way as to interfere with the normal alignment of teeth or impinge on the gingival (gums), it can be excised with surgery called a Frenectomy.

PURPOSE OF FRENECTOMY SURGERY: A Frenectomy is a simple surgical procedure that removes or loosens a band of tissue that is connected to the lip, cheek or floor of the mouth. The surgery can cause very little bleeding, does require sutures, and often result in some post-procedure discomfort. The procedure will be performed using local anesthetics.

RISKS RELATED TO THE SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related Frenectomy surgery might include post-surgical infection, bleeding, brushing, swelling, or pain. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of anesthesia.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in reducing the interference with the normal alignment of the teeth or impingement on the gingival (gums). It may need to be retreated. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and or/ alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

NITROUS OXIDE (optional): Nitrous oxide/Oxygen inhalation is mild form of conscious sedation used to calm an anxious patient. A colorless, odorless gas that has no explosive or flammable properties, it can act as a pain buffer as well. Oxygen is given simultaneously with the Nitrous Oxide through a small mask placed for the nose. Pure Oxygen, given at the end of treatment, is intended to flush the Nitrous out of the patient's system and minimize the effects of the gas. The patient remains awake and can respond to directions and questions. Nitrous Oxide helps overcome apprehension, anxiety, or fear. Nitrous risks include but are not limited to: Inability to perceive one's spatial orientation and temporary numbness and tingling. Nausea and vomiting may occur.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give consultation and treatment plan presentation by the doctor or as described in this document.

☐ I have read and fully understood the terms within this document and consent to the procedure as described above.

☐ I have read and fully understood the terms within this document and refuse to give my consent for the proposed treatment plan as described above. I have also been of and accept the consequence if no treatment is administered.

Signature: _____

Date: _____

Denture Approval Consent

Parkside Family Dental
Dental Approval Denture

This is to acknowledge that I am approving the appearance of my denture in shape, size, shade and contour of the teeth. I am aware that any changes that I require must be made at this time. Any changes following the completion of the denture will require an additional fee for the new denture and/or any time that may be required.

Signature:

Date:

Decline Treatment Consent

I, the undersigned patient, am refusing the procedure(s) or course(s) of treatment recommended by the undersigned provider. I understand that my decision is against the advice of the dentist.

I am aware of and understand my dental condition and have discussed several treatment options with the dentist. I have been presented with printed information describing these procedures and the risks and benefits associated with them.

I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall health may be affected by my decision. I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in my overall health stemming from this condition.

I have had the chance to ask questions and express concerns about my dental condition, the treatment options, and my refusal of treatment. The undersigned provider has answered all my questions and addressed all my concerns. I understand the full scope of the situation and am making an informed decision.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Signature: _____

Date: _____

Consent for Treatment

Parkside Family Dental
CONSENT FOR TREATMENT

I understand that I have conditions requiring dental treatment in the opinion of my dentist.

I, the undersigned patient, hereby authorized the undersigned provider to perform the procedure(s) or course(s) of treatment diagnosed. I understand my dental condition and have discussed several treatment options with the undersigned provider; I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all question and concerns have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures; understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of any emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have been given the opportunity to ask any questions I have concerning my diagnosis and treatment with the provider. My questions have been discussed and answered to meet my understanding.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing.

I confirm that I understand this form and the information contained therein.

Signature: _____

Date: _____

Root Canal Consent

Parkside Family Dental
Informed Consent
Endodontic (Root Canal) Treatment

I understand that endodontic (root canal) treatment for tooth/teeth #(s) _____ has been recommended by my dentist. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease problems.

Some complications of root canal treatment may be, but are not limited to:

- **Failure of the procedure necessitating re-treatment, root surgery, or extraction**
- **Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer**
- **Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery by a specialist for removal**
- **Perforation of the canal with instruments which may require additional surgical treatment by a specialist or result in the loss of the tooth**
- **Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other areas.**

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture.

I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me, and I have had a chance to have all of my questions answered.

Signature: _____

Date: _____

W/O Doctor Consent

Parkside Family Dental
Without Doctor Consent

KRS 313.040 allows a Licensed Dental Hygienist to treat patients without the doctor being present in the office if the doctor has examined the patient within the last 7 months.
The statute requires a signed consent form for a patient to be seen under General Supervision.

Signature:

Date:

PARKSIDE FAMILY DENTAL

Informed Consent

Prosthodontic Treatment
Crowns, Bridges, Veneers, Inlays and Onlays

I understand that a prosthodontic treatment has been recommended by my dentist for the following tooth/teeth #(s) _____. Dental crowns are restorations that cover or cap teeth, restoring them to their natural size, shape and color. A crown not only helps with appearance, but can strengthen a tooth as well. A fixed, or stationary bridge is designed to replace teeth that have been lost. Missing teeth may need to be replaced for appearance, or to prevent or correct bite and gum problems related to shifting or stressed teeth. Sometimes a crown covering the entire tooth is not necessary and an inlay, onlay, or veneer is required. An inlay restores the chewing part of a tooth without covering the cusps; an onlay restores the chewing part including the cusps; and a veneer covers the front part of a tooth. Dental crowns and bridges are made of ceramics/porcelain, resins or acrylics and may or may not have an inner layer of metal. Some may be made of metal alone. Dental inlays and onlays can be made of porcelain, resins, acrylic or metal; veneers are made without metal.

As with all procedures, there are certain potential problems associated with these restorations.
These include, but are not limited to the following:

- **Tooth sensitivity to heat, cold or air**
- **The potential need for root canal therapy. The cumulative effects of cavities, fillings and cracks in the teeth may necessitate a root canal. The need for a root canal may become apparent during a crown preparation, or after a crown is made.**
- **Periodontal (gum) disease can occur at any age, with or without these restorations. Generally speaking crowns, bridges, veneers, inlays and onlays, do not create or prevent gum disease.**
- **Fractures to the materials may occur after placement. Small fractures may be repaired, large fractures may require a new crown, bridge, veneer, inlay or onlay.**
- **Dark lines at the gumline may appear on crowns or fixed bridges lined with metal. This is the metal edge of the crown. If the gum recedes after placement, this metal will show. Sometimes this can be corrected, other times a new crown or bridge might be needed.**
- **Recurrent tooth decay can occur after placement. This may be corrected with a filling or a new crown or bridge might be needed.**
- **Food impaction may occur under a bridge or around other restorations. This may be an unavoidable condition. Meticulous home care is required.**
- **Temporomandibular Joint Dysfunction may occur due to changes in the bite following crowns, bridges, veneers, inlays and onlays. This can usually be corrected, but in rare occasions may cause symptoms requiring extensive treatment.**

I understand the recommended treatment, the risks of such treatment, any alternatives have been explained to me and the risks of these alternatives, the consequences of doing nothing about my condition, and the fee(s) involved.

Patient Signature _____ **Date** _____

Print Name _____

Witness _____

Submit