Isterabadi Inc. Family Dentistry Informed Consent

Patient Name:_____
Date:_____

1. TREATMENT TO BE DONE: I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete the examination and any additional appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there is a need for a referral to a specialist deemed necessary by Dr. Isterabadi, then the cost of this referral would be my responsibility. **Initials**___

2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics and other medications can cause allergic reactions creating clinical symptoms such as redness, swelling, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that it is my responsibility to inform Dr. Isterabadi of any allergy to specific medication to avoid possible adverse effects that Dr. Isterabadi may prescribe. **Initials**___

3. LOCAL ANESTHETICS: The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate but will be normal. Common complications that can occur from local anesthetic but are not limited to pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness and even death. **Initials**___

4. CHANGES IN TREATMENT PLAN: I understand that during treatment, it may be necessary to change or add procedures due the conditions found while working on the teeth that were not discovered during examination, the most common being a root canal therapy following routine restorative procedures. I give my permission to Dr. Isterabadi to make any/all changes and additions as necessary once I have been informed of these changes and consent to them. I also understand that by not accepting Dr. Isterabadi's recommendation, delayed treatment can lead but will not be limited to more discomfort, increase in the complexity of the treatment outcome or eventual loss of teeth. **Initials**___

5. EXTRACTIONS (REMOVAL OF TEETH): I give my consent to Dr. Isterabadi to perform the extraction/surgery to treat and possibly correct my diseased oral tissue or other procedures deemed necessary to complete the planned operation/extraction. If left untreated, the risks to my health may include, but are not limited to swelling, pain, infection, abscess, gum disease, dental decay, malocclusion, and premature loss of teeth and/or bone. Dr. Isterabadi has informed me of possible alternative methods of treatment. Potential risks include, but are not limited to the following: **Initials**___
    a. Post-operative discomfort; stretching of the corners of the mouth, with resultant cracking and bruising, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage possibly exposing crown margins, tooth looseness, delayed healing dry socket and/or infection requiring prescription or additional treatment (i.e. surgery)
    b. Injury to adjacent teeth, prosthesis, and/or restorations which may require additional treatment or injury to other tissues not within the described surgical area.
    c. Limitation of opening, stiffness of facial and/or neck muscles, a change in bite or tempromandibular jaw joint, difficulty of possibly requiring physical therapy or surgery.
    d. Residual root fragment or bones spicules left when complete removal would require extensive surgery or needless surgical complications.
    e. Possible bone, and/or jaw fractures, or opening of the maxillary sinus requiring additional surgery.
    f. Injury to the nerve underlying the teeth resulting in itching, numbness or burning of the lip, chin, gums, cheek, teeth and/or tongue, which may be temporary or permanent.
    If any unforeseen condition should arise in the of the operation/extraction, calling for Dr. Isterabadi's judgment or for procedures in addition to or different from those are now contemplated, I request and authorize Dr. Isterabadi to do whatever he may deem advisable, including referral to another dentist or specialist.

6. CROWNS, BRIDGES, AND CAPS: I understand sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns and bridges, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns and bridges are delivered. I understand that if my temporary crowns come off, then it is my responsibility to return to Dr. Isterabadi to have it re-cemented. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, size and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns, or bridges, it may not fit properly, and I will be responsible for any labs fees. **Initials**___ Shade___

7. DENTURES – COMPLETE OR PARTIAL: I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture including shape, fit, size, placement and color; will be the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relinements is not included in the initial denture fee. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachments and/or other complicating factors, I may never be able to wear dentures to my satisfaction. **Initials**___ Shade___
8. ENDODONTIC TREATMENT ROOT CANAL: The purpose and method of root canal therapy have been explained to me as well as the consequences of non-treatment and reasonable alternative treatments. I understand that following root canal therapy my tooth will be brittle and must protected against fracture by placement of a final restorative (usually a crown cap) over the tooth. I also understand that sometimes root canal therapy may fail and further treatment may be necessary that might include but not limited to retreatment, apicoectomy, or extraction. I understand the treatment risks can include, but are not limited to the following: **Initials**___
    a. Post treatment discomfort, infection, restricted jaw opening
    b. Swelling of the gums in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
    c. Separation of root canal instruments during treatment which may in the judgment of Dr. Isterabadi be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
    d. Perforation of the root canal which may require additional surgical treatment, or premature tooth loss extraction.
    e. Risk of temporary or permanent numbness in treatment vicinity.
    f. The root canal filling material may be overfilled or underfilled, which may or may not affect the success/outcome of the treatment.
9. PERIODONTAL (LOSS OF TISSUE & BONE): I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (brushing, flossing, etc.) and maintaining regular recall and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to the loss of my teeth and other related systemic complications. The various treatment plans have been explained to me, including non-surgical scaling and root planning follow by local irrigation with oral medicaments and local delivery of antibiotics, or gum surgery, or replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for a referral to a Periodontist. **Initials**___
10. FILLINGS: I have been advised of the need for fillings (either silver or composite plastic). In cases where very little structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment such as root canal therapy, post and build-up and/or a crown, in which would necessitate a separate charge. In understand that my recently placed fillings may cause some sensitivity and discomfort for a duration and may be alleviated with time. However, I understand that if the symptoms and sensitivity worsen, then I might need root canal therapy. **Initials**___
11. PEDODONTICS (CHILDREN'S DENTISTRY): I understand the following procedures are routinely used in conjunction with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized caregiver, I understand and give consent that the following procedures can be used on my child: **Initials**___
    a. POSITIVE REINFORCEMENT: rewarding the child who portrays desirable behavior, by use of compliments, verbal praises, or toys.
    b. VOICE CONTROL: the attention of disruptive child is gained by changing the tone or increasing the volume of Dr. Isteratbadi's voice.
    c. PHYSICAL RESTRAINT: as the parent or authorized caregiver, I have been informed in advance and have given consent as it may be deemed necessary to restrain the child. Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the Dr. Isterabadi's or the assistant's hand or arms, or by use of a specific device referred to as the "papoose board".
    d. I understand with the use of local anesthetic for dental purposes, the possibility exists that the child may inadvertently bite their lip, tongue, and cheek causing injury to occur.

I understand the dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I have read and clearly understood the consent form language, and by signing below I acknowledge this understanding and give my consent to Isterabadi Incorporated to perform the above indicated procedure(s). Dr. Isterabadi has encouraged me to ask questions. I have had the opportunity to ask questions and any and all of my questions have been answered to my satisfaction.

Signature:_____ Date:_____

Doctor:_____Witness:_____