DENTAL SMILES OFLIVONIA, P.C. · 33044 FIVE MILE ROAD · LIVONIA, MI 48154 (734) 525-2552

INFORMED CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risk of the recommended procedures, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with our dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment included, but are not limited to, the following:

1. Pain, swelling and discomfort after treatment;
2. Infection in need of medication, follow-up procedures or other treatment;
3. Temporary, or ,on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste;
4. Damage to adjacent teeth, restoration or gums;
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future;
7. An altered bite in need of adjustment;
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop;
10. Jaw fracture;
11. If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment;
12. Allergic reaction to anesthetic or medication;
13. Need for follow-up care and treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointment. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

WITNESS:

_____ _____
Patient's signature

_____ _____
Signature of patient's parent (if a minor)
or legal guardian

Date: _____

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize payment of the dental benefits otherwise payable to me directly Kristal Greniuk-Wioncek D.D.S.

Insured's Signature _____

Staff Signature _____

Dr.'s Initials _____ Date_____

The above authorizations expire one year from the date of signature.