Rancho
DENTAL PRACTICE

Family Orthodontics & Cosmetic Dentistry

Informed Consent For Dental Treatment

Patient Name:____ Date: ___________________

As a patient of Rancho Dental Practice, the Doctors and staff want you to be familiar with the possible types of treatment that you may require. Please read each paragraph about a treatment type and initial at the blank. Your specific treatment will be diagnosed and written on a separate form. You are welcome to a copy of the treatment form if you request it.

1. **Drugs and Medication**
   I understand that antibiotics and other drugs may cause allergic reactions and I have informed RDG of any allergies that I have.
   Initials:_________

2. **Changes in Treatment Plan**
   I understand that a treatment plan may have to be changed as dictated by and for my health. For example a deep filling may need a root canal and is only evident after the decay is removed. A crown may be needed because a filling would be too large.
   Initials:__________

3. **Removal of Teeth**
   I have been informed of the alternatives to the extraction of teeth and I elect to have the teeth removed that are indicated on my treatment plan.
   Initials:__________

4. **Crowns, Bridges and Caps**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with the 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 permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridges or cap (including size, shape, color and fit), will be before cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for the remake due to my delay of cementation.
   Initials:__________

5. **Endodontic Treatment (Root Canals)**
   I realize there is no guarantee that root canal treatment will save my tooth and complications can occur from the treatment and that occasionally root canal filling material may extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it.
   Initials: __________

6. **Periodontal (Gum) Loss**
I understand that I may have a serious condition causing gum and bone inflammation or loss and that it can lead to loss of my teeth. Alternative treatment plans have been explained to me, including the possibility of gum surgery with a Periodontist (gum specialist). I understand that undertaking any dental procedures before gum treatment may have a future adverse effect on my periodontal condition.
Initials: __________

7. **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 effect of a newly placed filling
Initials: __________

8. **Dentures/Part Partial Dentures**
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later, as well as potential remake.
Initials: __________

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee all results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other doctor of Arranz Family Dentistry (Formerly Rancho Dental Group) is responsible for my treatment.

I hereby authorize any doctors or auxiliaries of Arranz Family Dentistry (formerly Rancho Dental Group) to proceed with and perform the dental restorations and treatments 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 may have, I am responsible for payment of all dental fees. I agree to pay any attorney's fees, collection fees, or court cost that may incur to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is whether any dental services rendered as allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed, said dispute will be submitted to Peer Review by local component of the American Dental Association. The decision of Peer Review shall be binding on both parties. I have read, understood and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Signature:____ Date: ______________________
(Patient, Spouse, Parent or Guardian)

OFFICE USE ONLY

Staff	Doctor	Date
______________________	______________________	______________