Welcome to the Office of Steven P. Ray, D.D.S., P.A

11811 Hinson Road, Suite 200
Little Rock, AR 72212
Tel: (501) 312-1127

Consent for Dental Treatment

Patient Name: _____ Date: _____

Please initial each paragraph after reading. If you have any questions, please ask the doctor before initialing.

1. **TREATMENT:**

_____ I understand that I may need to have the following dental treatment performed:

- ☐ Filling
- ☐ Crown
- ☐ Bridge
- ☐ Dentures
- ☐ Extraction
- ☐ Impacted Tooth Removal
- ☐ Root Canal
- ☐ Implants
- ☐ Treatment of Periodontal Disease
- ☐ Other

_____ 2. **DRUGS AND MEDICATIONS**

I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling of tissue, itching, pain, nausea and vomiting or more severe allergic reactions have informed my doctor of any known allergies. Certain medications may cause drowsiness and it is advisabl not to drive or operate hazardous equipment when using such drugs.

_____ 3. **RISKS OF DENTAL ANESTHESIA:**

I understand pain, bruising and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial structure can occur with "shots". About 90% of these cases resolve themselves i less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possible treatmer may be needed if the symptoms do not resolve.

_____ 4. **FILLINGS:**

I understand that a more extensive restoration than originally planned, or possible root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restorations. I realize that fillings are rarely permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ 5. **CROWNS, BRIDGES:**

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify Dr. Ray of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes that I may desire in color, shape, size, etc. of a crow must be made prior to the final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of restoration.

_____ 6. **DENTURES:**

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished and tha dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infections, I could experience denture related problems such as: shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used t these symptoms quickly while others take time and there are a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate denture requires frequent adjustments and one or more relines within several montl I understand that failure to keep appointments may result in a less than desirable outcome. After all adjustments are made and I am completely satisfied then a final set of dentures will be made. If a remake is required due to my delay, additional fees may be incurred.

7. **EXTRACTIONS**

Alternatives to tooth removal include root canal therapy, extensive restorations, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include but are not limited to: pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also there is the possibility of a small root piece being left in the jaw where the risks of removing it outweighs the benefits. I understand that further care may be necessary.

8. **PERIODONTAL:**

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lea to loss of permanent teeth, heart disease and risk of stroke. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faith adherence to following Dr. Ray's instructions, including strict observation of recall (cleaning) appointments.

9. **ROOT CANAL THERAPY**

I realize root canal therapy has a very high success rate; however, there is no guarantee root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require an extraction. These include; extensive decay making the tooth not restorable perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely frag instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery treatment. A small percentage of root canals fail despite the best efforts. After root canal therapy, a crown is usually needed, if not placed right away, it might lead to fracture of the tooth and possible extraction.

10. **IMPLANTS**:

I understand the purpose of dental implant procedures is to provide support to an existing denture, partial denture, or to restore an area that is missing a tooth. This process may take steps until I have the finished product. In the event that the implants fail, they will be removed through a subsequent surgical procedure. I understand that one or more of the implants may fracture during insertion or during the implants life cycle. if a fracture occurs, I give consent to leave the implant in my jaw. I further understand that swelling, infection, bleeding, and or jaw pain may be associated with this or any surgical procedure and that said conditions may occur in my tongue, lips, chin, gums or jaw as a result of this procedure.

I understand that dentistry is not an exact science and that no specific result can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during t course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by Dr. Ray, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with the treatment. I hereby give my consent for the treatment I have chosen.

Patient or Guardian Signature _____ Date _____

Steven P. Ray, D.D.S. _____ Date _____

Witness _____ Date _____