South River Dentistry
Consent for Dental Treatment

Patient Name: ___________________________ Date: __________________

I hereby consent/refuse to the following described dental procedures upon me by or under the direction of South River Dentistry, a division of CVDC, their associates and assistants. In the event that South River Dentistry becomes unavailable, I authorize them to select a replacement to accomplish the agreed upon procedures without delay. I acknowledge that the following information has been provided to me.

Nature of my dental illness: Periodontal Disease, Abscessed tooth, Cracked Broken tooth, Teeth with failing restorations, Unrestorable teeth, Decayed teeth, Missing teeth, Posterior (back) bite collapse, Bite Problems, Dental Implants, other
_______________________________________________________________________________.

The purpose of the following procedure is to correct, restore or improve the above conditions.

Treatments: I understand that I am having the following dental treatment done: (please read and initial the items checked below)

1. Anesthesia and Medications
I consent to administrations of local anesthesia and other drugs deemed necessary in my case and understand the risks of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/or permanent nerve damage or other unforeseeable complications which may result from the administration of a drug or anesthetic.
Initials:

2. Periodontal Therapy (Periodontics)
I understand that I have a serious condition causing gum and bone infection or loss that can lead to the loss of my teeth. Alternative treatment has been explained to me including gum surgery, tooth replacements and/or extractions. I understand that not undertaking any dental procedure may have a future adverse effect on my periodontal condition.
Initials:

3. Root Canals (Endodontics) and Posts
I realize there is no guarantee that root canal therapy and posts will save my tooth, and that complications can occur from the treatment. Complications can include breakage of metal objects in the tooth and over extension of cement or filling materials outside the root tip that may result in permanent nerve damage. I further understand that although rare, perforations (going out the side of the tooth) can occur. I am also aware that, after root canal therapy a post and core buildup, crown or onlay will need to be placed on the tooth.
Initials:

4. Tooth and Tissue Removal (Oral Surgery)
Alternatives to removal have been explained to me (root canals, crowns, and periodontal surgery, etc) and I authorize South River Dentistry, a division of CVDC, their associates and assistants to remove the following teeth _________ and any other necessary for reasons described in the first paragraph above (nature of my dental illness). I understand that removing teeth does not always remove all the infection and if infection remains it may be necessary to have further treatment. I understand some of the possible risks and complications include but are not limited to pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last an indefinite amount of time and/or a fractured jaw. I understand I may need further treatment by a specialist for complications, which may arise during, or following treatment; the cost of which is my responsibility. I understand that tooth replacement will be necessary soon after the removal of my teeth, except wisdom teeth – 3rd molars.
Initials:

5. Tooth Colored Fillings (Composites)
I understand that my teeth need new or replacement fillings. Certain side effects can include hot, cold, and/or biting sensitivity (pressure). With larger cavities, root canals and/or crowns may be necessary to stabilize my tooth/teeth. (Occasionally a "high spot" in your bite may develop after the numbness has worn off. If this occurs, please contact our office immediately for an adjustment of the "high spots"). I understand it is sometimes not possible to match the color of natural teeth exactly with artificial filling materials.
Initials:
6. Tooth Colored/Gold Crowns and Bridges
I understand that I may be wearing temporary crowns or bridges, which may come off easily, and that I must be careful to ensure they are kept in place until the custom crown or bridges are placed. I further understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand the final opportunity to make changes in my new crowns/bridges color, shape, fit or size is before cementation. I realize that some crowns and bridges are used to treat decay and fracture and therefore may require root canal therapy during or after treatment if symptoms arise.
Initials:

7. Partial and Complete Dentures
I realize that complete or partial dentures are artificial and are constructed of plastic, metal and/or porcelain. The problems in wearing these appliances, which have been explained to me, include looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including fit, size, placement, and color) will be the “Teeth in Wax” visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee. I also understand that all adjustments are included for one month following the placement of the denture. Any future adjustment will have a fee.
Initials:

8. Dental Implants
Alternatives to replacement with Dental Implants have been explained to me and I authorize South River Dentistry, a division of CVDC, their associates and assistants to place Dental Implants. I understand that implant surgery involves the placement of metal anchors into the jawbone. I understand 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, pain, post-operative bleeding requiring treatment, delayed or inadequate healing or infection requiring removal of the implant. (A new implant may or may not be possible in a later surgical procedure.) Another risk may be a loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last an indefinite amount of time, possible involvement of the sinus, nerves, or nasal cavity which may require removal of the implant. Other risks include, re-infection or poor toleration to the implant necessitating removal, and difference in the appearance of the prosthetic replacement from the original teeth. I understand that crowns, and/or partial dentures or complete dentures will be needed after the implant is placed.
Initials:

9. Teeth Whitening
Significant whitening can be achieved in the vast majority of cases, but individual results vary. Some patients may experience teeth sensitivity or a burning sensation in their gums, which usually resolves itself within 24 hours.
Initials:

10. Photographs
I consent to be photographed before, during and after the procedure(s) to be performed, only in the mouth and neck region of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
Initials:

11. Financial Responsibility
I understand that South River Dentistry, a division of CVDC, and their team feel that dental treatment is an excellent investment in an individual’s medical and psychological well-being and financial considerations should not be an obstacle to obtaining this important health service. In their efforts to make their services more affordable for the patients, they have several forms of payment. Regardless of method of payment I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers compensation and the like. I also agree to pay for services when they are rendered unless other arrangements have been made with the financial coordinator. I authorize Jeff T. Blackburn, DDS, a division of CVDC, for the benefit otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all of the charges arising for the treatment of the above named patient. If this contract is referred to an attorney for collection, I agree to pay attorney’s fees and the total indebtedness and court costs incurred by Jeff T. Blackburn, DDS, a division of CVDC. If this indebtedness is not paid in full within thirty (30) days from the last date of service, I agree to pay a service charge of one and one-half (1 & ½) percent per month, eighteen (18) percent interest per annum on the unpaid balance.
I consent to the performance of operations and procedures in addition to or different from those above contemplated which South River Dentistry, a division of CVDC, or their associates and assistants consider therapeutically necessary even though this procedure may be an emergency. I understand that the extension of this procedure may include risks not previously discussed but, nevertheless, grant to South River Dentistry, a division of CVDC, their associates and assistants, the authority to proceed with such additional procedures.
I further consent to the disposal of tissue or parts removed at the time of the operation. I realize that it is mandatory that I give as accurate and complete medical and personal history as possible and that I have done so.
I further agree to follow any and all instructions as directed and permit prescribed diagnostic procedures. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have requested authorized.
I further acknowledge that I have been given full opportunity to discuss the matters contained herein with South River Dentistry, a division of CVDC, their associates or assistants and that I understand the information provided.
Initials: