The Dental Office of Dr. Unsil Keiser and Dr. Varsha Kulkarni

The following information will help you more thoroughly understand dental procedures and our office policies. If you have any questions, please let us know so we can discuss them with you. Please initial, sign, and date where indicated.

_____ *initials* *

Diagnostic Procedures and Treaments. I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and/or authorized. I understand that I have the right to have questions answered to my satisfaction and that I will be presented with a proposed treatment form before any work is done. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. ***I am responsible to inform this office of any change in my health history.***

_____ *initials* *

Prophpylaxis. Dental prophylaxis is a teeth and gum cleaning treatment that helps in treating gingivitis and helps to keep gums and teeth healthy. It also helps with bad breath and removes the plaque, tartar, and external stains from teeth. I understand that my teeth and gums may be a little sore and/or sensitive for a few days after prophylaxis treatment.

_____ *initials* *

Oral Cancer Screening. I understand that my dentist seeks to provide me access to the newest and most effective scientific screening and treatment. In 2009 the StarDental® Indentafi® system was introduced. This multispectral medical device greatly enhances the ability to find early signs of cancer and dysplasia in the mouth. Historically, this practice has used white light in examination for oral cancer, but the use of narrow band violet light and green-amber reflected light will help detect in the oral tissue various problems including cancer lesions and dysplasia. I understand that early detection of oral cancer is important so that I might obtain early treatment and avoid problems which arise from late stage detection of oral cancer. I understand that I am encouraged to discuss any questions related to detection of oral cancer.

*please select **one** checkbox at right* *

☐ **I consent to** and request that my dentist perform the StarDental® Indentafi® examination and I accept financial responsibility for this examination. I understand that by consenting to the StarDental® Indentafi® screening, ***I will be charged $20 for the screening.***

☐ **I reject** using the StarDental® Indentafi® for my oral cancer screening. I understand that I will still be given a conventional oral cancer screening.

_____ *initials* *

Changes in My Treatment Plan. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination or by xray. For example, the necessity for root canal therapy following routine restorative procedures cannot always be detected by xray. I understand that any and all changes and additions to my treatment plan will be discussed with me.

_____ *initials* *

Drugs & Medications. I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, or anaphylactic shock (severe allergic reaction). ***I understand that it is my responsibility to inform the dentist of any known allergies to medication.***

_____	_____	_____
Patient Name (please print)	*Patient/Parent Signature*	*Date*

_____ *initials*

Risks of Dental Anesthesia. I understand that pain, bruising, and occasional temporary (and sometimes permanent) numbness in lips, cheeks, tongue, and associated facial structures can occur with injected local anesthetics (shots). About 90% of these cases resolve themselves in less than eight weeks. Although rare, a referral to a specialist for evaluation and treatment may be needed if symptoms do not resolve.

_____ *initials*

Women on Birth Control Pills. Birth control pills become ineffective when taken along with antibiotics. ***I understand that I will need to use double protection for the rest of my cycle if I am taking antibiotics, or I could become pregnant.***

_____	_____	_____
Patient Name (please print)	*Patient/Parent Signature*	*Date*

_____ *initials*

_____ *date*

Nitrous Oxide. I understand that I have the right to elect to have nitrous oxide in conjunction with my dental treatment. I understand that possible side effects may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache, or in rare cases may cause hospitalization or death. ***I also understand that nitrous oxide use is not indicated if I am pregnant or have certain breathing problems.***

_____ *initials*

_____ *date*

Osteonecrosis of the Jaw is a rare condition that occurs when the bone is injured and dies. It happens when bones don't heal properly after procedures such as an extraction. If I have osteoporosis and am taking biphosphonate medication such as Actonel, Benefos, Ostac, Clasteon, Fosamax, or Boniva, I may be at risk of possible complications that may lead to osteonecrosis after an extraction. Complications may arise and ***it is my responsibility to inform the dentist if I am taking any medications classified as biphosphonates.***

_____ *initials*

_____ *date*

Laser. I understand that the laser uses light energy to do fillings, soft tissue surgeries, and bone surgeries. I understand that complications can arise where the area treated may have several days of swelling, pain, redness, and sensitivity due to the treatment in the area.

_____ *initials*

_____ *date*

Fillings. I understand that a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that sensitivity is a common aftereffect of a newly-placed filling. I understand that fillings are rarely permanent. Fillings are under warranty for the first year.

_____ *initials*

_____ *date*

Removal of Teeth. I understand there are alternatives to removal of teeth (root canal therapy, crowns, periodontal surgery, etc.). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain; swelling; spreading of infection; dry socket; exposed sinuses; loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parathesia) that can last for an indefinite period of time; or fractured jaw. If such complications arise, I understand the cost of further treatment by a specialist or hospitalization (in extremely rare cases) is my responsibility. I also understand there is a possibility of a small root piece being left in the jaw where risks of removing it outweigh the benefits.

_____ *initials*
_____ *date*

Crowns, Veneers, Onlays, and Bridges. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial material. I further understand that I may be wearing temporary crowns, which come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive days may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. Under some crowns or bridges some forms of metal may be used to improve strength. I understand that a more extensive restoration may lead to other measures necessary to restore the tooth to normal function, such as a root canal treatment, etc. I understand that sensitivity is a common aftereffect of newly placed onlays/crowns. I realize that onlays/crowns are rarely permanent. Crowns do last a long time if they are well taken care of. I understand that careful oral hygiene habits are necessary to make them last longer. I understand that habits such as chewing on hard food, clenching, or grinding may make my crowns break or come off. I understand new crowns are under warranty for one year and that my dentist will redo them at no cost to me if they break or come off during the first year of service.

_____ *initials*
_____ *date*

Fixed Bridge Replacement. I may elect to have a fixed bridge replacement of missing teeth instead of a removable appliance. I understand that a fixed bridge may not be a covered benefit under my insurance policy.

_____ *initials*
_____ *date*

Scaling/Root Planing, Periodontal Maintenance/Full-Mouth Debridement. I understand that periodontal disease is a serious condition, causing gum and bone inflammation, and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that periodontal disease may have a future adverse affect on the long-term success of dental restorative work and my general health. I understand that much of the success of periodontal treatment depends on my strict adherence to oral hygiene and recall appointments. A specialist appointment might be needed. Scaling and Root Planing, Perio Maintenance, and Full Mouth Debridement as one of the initial treatment has been discussed with me. Scaling and Root Planing removes the tartar, plaque, and bacterial toxins under the gum along the root surface of the tooth, offering a conducive environment for tissues to heal and regenerate and prevent further bone and gum loss. Response to this treatment varies. Temporary sensitivity, pain, soreness and bleeding may occur after treatment. The treatment, benefits, and risks of possible complications have been explained to me, and all my questions have been answered to my satisfaction. No promises or guarantees have been made about the results of the treatment.

_____ *initials*
_____ *date*

Bleaching is a procedure done either in the office (approximately 1 hour) or with take-home trays (2 weeks). I understand the degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental guide). I understand that coffee, tea, and tobacco will stain teeth after treatment so I should avoid those for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The doctor may prescribe fluoride treatments for rare cases of persistent sensitivity. I understand that carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics and their use as bleaching agents has unknown risks. I understand that acceptance of treatment means acceptance of risk. ***I understand that if I am pregnant, I am advised to consult with my physician before starting treatment.***

Patient Name (please print)	*Patient/Parent Signature*	*Date*

_____ *initials*

_____ *date*

Endodontic Treatment (Root Canal). I understand that root canal therapy has a very high success rate; however, there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment. During the procedure, some complications or conditions might be noted which would require either a referral to a specialist or a tooth extraction. These include, but are not limited to, extensive decay that makes the tooth un-restorable, perforations, fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier, leading to persistent pain and infection. I understand I might need a specialist referral if any complications or unexpected outcomes occur. Occasionally the canal filling material may extend through the tooth root tip, which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard-to-detect root fractures are one of the main reasons why root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. A crown also helps prevent a root canal from being re-infected. I understand that endodontic files and reamers are very fine instruments and stresses in their manufacture or unique tooth anatomy such as curvatures in tooth roots can cause them to separate during use which may or may not affect the success of the procedure. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

_____ *initials*

_____ *date*

Occlusal Guard. I understand that an occlusal guard may minimize the possible harmful effects of occlusal habits including sensitive teeth, worn teeth, cracked or fractured teeth. I also understand that the occlusal guard will not prevent my occlusal habits from continuing but rather introduce a protective material between my upper and lower teeth to minimize additional damage or symptoms of occlusal stress. It is only effective while it is being worn and provides no protection during times when it is not worn. I have been informed that the symptoms I may currently have may be the result of occlusal habits. There may be other dental and systemic conditions that may be contributing to my symptoms. Further evaluation for other causes may be necessary. I fully understand that a referral to a TMJ specialist may be necessary in the future depending on my response and the durability of the material over time with my particular occlusal habits. I have been informed that my condition can sometimes be treated simply over the short term or could require treatment over several years and could include orthodontic treatment, restoration with crowns, bridges, implants, or surgery. I have had an opportunity to ask questions and am fully satisfied with the answers I have received. I understand the occlusal guard will/may require replacement if it is lost, damaged, or worn, or if the underlying teeth are changed (with new fillings, crowns, bridge, etc.). Additional fees will apply if replacement is necessary.

_____ *initials*

_____ *date*

Dentures: Complete or Partial. I understand that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain, and can never be the same as natural teeth. It may require a lot of effort on my part to get used to them. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I understand the final opportunity to make changes in my new dentures (including shape, fit size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first; they may require several adjustments and reline. A permanent or temporary reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand it will be my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. I understand that no guarantees have been made regarding the success of dentures or the ability of getting used to wearing them. I understand that dental implants are strongly recommended to patients for better results. I understand that choosing dentures means accepting the risks and limitations that come with them. I understand that I many never get used to dentures and will require other forms of treatment.

Patient Name (please print)	*Patient/Parent Signature*	*Date*