GRANDVIEW DENTAL

Enhancing Smiles and Changing Lives

NITROUS OXIDE INFORMED CONSENT

I hereby give permission for Dr. Collins and staff to perform nitrous oxide sedation. I understand that the administration of medication and the performance of conscious sedation with nitrous oxide carries certain common hazards, risks, and potential unpleasant side effects which are infrequent, but non the less, may occur. They include but are not limited to the following:

1. Excessive Perspiration: Sweating may occur during the procedure and you may become somewhat flushed during administration of nitrous oxide.
2. Expectoration: Removal of secretions may be difficult but can be controlled by use of suction tip.
3. Behavioral Problems: Some patients will talk excessively. You may become difficult to treat because you are so talkative, or experience vivid dreams associated with physical movement of the body.
4. Shivering: Although not common, shivering can be quite uncomfortable. Shivering usually develops at the end of the sedative procedure when the nitrous oxide has been terminated.
5. Nausea and Vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low. It is important to tell the doctor, hygienist, or assistant that you are experience some discomfort. The level of nitrous oxide can be adjusted to eliminate this side effect.
6. Driving a Motor Vehicle: You may not feel capable of driving after nitrous oxide. If this occurs, we will keep you until you feel better or have you call a friend or cab to insure your safety.

I have been advised of alternative treatment, the benefits and risks which include but are not limited to:

Fear and anxiety of the dental experience and/or avoidance of future dental appointments. These fears and anxiety, if not diminished by the use of nitrous oxide sedation, may precipitate other medical problems including fainting, palpitation and other heart-related disorders.
The benefits one can expect from nitrous oxide sedation include:
Help with anxiety and pain, gagging and medically compromised individual.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but no guarantees have been made to the result of the procedure authorized above.

Signature_____ Date_____

Witness_____ Date:_____

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CONSENT FOR FILLINGS

Treatment: I understand that I am having the following dental treatment performed:

COMPOSITE RESIN FILLINGS

Drugs and Medications: I understand that medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Collins of any known allergies. I have been informed of all medications prescribed to me. I agree not to drive or operate hazardous equipment when using certain medications.

Fillings: I understand that it is sometimes not possible to exactly match the color of natural teeth. I understand that a more extensive restoration than originally planned may be required due to significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely permanent" and usually require periodic replacement. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

Changes in Treatment Plan: Dr. Collins makes every effort to completely and accurately diagnose your dental treatment, however, I understand that during treatment it may be necessary to change or add procedures because of conditions discovered that were not evident during examination. I authorize Dr. Collins to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I acknowledge that no such guarantees have been made regarding the 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 the course of treatment.

Consent: I have had the opportunity to have all my questions answered by Dr. Collins. My electronic signature in my chart signifies that I understand the treatment, anesthesia, and medications that are proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

Patient signature _____ date: _____

Witness: _____ date: _____

GRANDVIEW DENTAL

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CONSENT FOR CROWN AND BRIDGES

Treatment: I understand that I am having the following dental treatment performed:

CROWN AND BRIDGE_____

Drugs and Medications: I understand that medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Collins of any known allergies. I have been informed of all medications prescribed to me. I agree not to drive or operate hazardous equipment when using certain medications.

Crowns and 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 to be recemented. I will notify Dr. Collins of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return within two months of tooth preparation for final cementation of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

Changes in Treatment Plan: Dr. Collins makes every effort to completely and accurately diagnose your dental treatment, however, I understand that during treatment it may be necessary to change or add procedures because of conditions discovered that were not evident during examination. I authorize Dr. Collins to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I acknowledge that no such guarantees have been made regarding the 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 the course of treatment.

Consent: I have had the opportunity to have all my questions answered by Dr. Collins. My electronic signature in my chart signifies that I understand the treatment, anesthesia, and medications that are proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

Signature_____ **date:**_____

Witness_____**- date:**_____

GRANDVIEW DENTAL

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CONSENT FOR EXTRACTIONS

Treatment: I understand that I am having the following dental treatment performed:

EXTRACTIONS

Drugs and Medications: I understand that medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Collins of any known allergies. I have been informed of all medications prescribed to me. I agree not to drive or operate hazardous equipment when using certain medications.

Extractions: Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness is generally temporary, however, occasionally permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment and that costs incurred are my responsibility.

Changes in Treatment Plan: Dr. Collins makes every effort to completely and accurately diagnose your dental treatment, however, I understand that during treatment it may be necessary to change or add procedures because of conditions discovered that were not evident during examination. I authorize Dr. Collins to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I acknowledge that no such guarantees have been made regarding the 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 recognised only during the course of treatment.

Consent: I have had the opportunity to have all my questions answered by Dr. Collins. My electronic signature in my chart signifies that I understand the treatment, anesthesia, and medications that are proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

Signature:_____ date:_____

Witness:_____ date:_____

GRANDVIEW DENTAL

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CONSENT FOR ROOT CANAL

Treatment: I understand that I am having the following dental treatment performed:

ROOT CANAL

Drugs and Medications: I understand that medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Collins of any known allergies. I have been informed of all medications prescribed to me. I agree not to drive or operate hazardous equipment when using certain medications.

Root Canal Therapy: I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not effect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root which may or may not effect success. I understand that occasionally additional surgical procedures may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise.

Changes in Treatment Plan: Dr. Collins makes every effort to completely and accurately diagnose your dental treatment, however, I understand that during treatment it may be necessary to change or add procedures because of conditions discovered that were not evident during examination. I authorize Dr. Collins to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I acknowledge that no such guarantees have been made regarding the 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 recognised only during the course of treatment.

Consent: I have had the opportunity to have all my questions answered by Dr. Collins. My electronic signature in my chart signifies that I understand the treatment, anesthesia, and medications that are proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

Patient signature: _____ date:_____

Witness signature:_____ date:_____

GRANDVIEW DENTAL

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CONSENT FOR PERIODONTAL DISEASE TREATMENT

Treatment: I understand that I am having the following dental treatment performed:

DEEP SCALING AND ROOT PLANING

Drugs and Medications: I understand that medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Collins of any known allergies. I have been informed of all medications prescribed to me. I agree not to drive or operate hazardous equipment when using certain medications.

Periodontal disease: Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. 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 faithful adherence to following my Dr. Collins' instructions including strict observance of recall appointments. I understand that care by a specialist may be necessary

Changes in Treatment Plan: Dr. Collins makes every effort to completely and accurately diagnose your dental treatment, however, I understand that during treatment it may be necessary to change or add procedures because of conditions discovered that were not evident during examination. I authorize Dr. Collins to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed.

I acknowledge that no such guarantees have been made regarding the 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 recognised only during the course of treatment.

Consent: I have had the opportunity to have all my questions answered by Dr. Collins. My electronic signature in my chart signifies that I understand the treatment, anesthesia, and medications that are proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent.

Patient signature _____ date: _____

Witness signature: _____ date:_____

Bone Grafting and Barrier Membrane Consent Form

I understand that bone gaffing and barrier membrane procedures include inherent risks such as but not limited to the following:

1. Pain. Some discomfort is inherent in any oral surgery procedure. Grafting with materials that do not have to be harvested from your body are less painful because they do not require a donor site surgery. If the necessary bone is taken from your chin or wisdom tooth area in the back of your mouth there will be more pain. It can be largely controlled with pain medications.
2. Infection. No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.
3. Bleeding, bruising, and swelling. Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.
4. Loss of all or part of the graft. Success with bone and membrane grafting is high. Nevertheless, it is possible that the graft could fail. A block bone graft taken from somewhere else in your mouth may not adhere or could become infected. Despite meticulous surgery, particulate bone graft material can migrate out of the surgery site and be lost. A membrane graft could start to dislodge, If so, the doctor should he notified. Your compliance is essential to assure success.
5. Types of graft material. Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by different means to be free from contaminants. Signing this consent form gives your approval for the doctor to use such materials according to his knowledge and clinical judgment for your situation.
6. Injury to nerves. This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur, may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
7. Sinus involvement. In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus. Occasionally, with extractions and/or grafting near the sinus, the sinus can become involved. If this happens, you will need to take special medications. Should sinus penetration occur, it maybe necessary to later have the sinus surgically closed.
8. It is your responsibility to seek attention should any undue circumstances occur post-operatively and you should diligently follow any pre-operative and post-operative instructions.

Informed Consent: As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Kandace Collins and her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patients name _____

Signature of patient, legal Guardian, or authorized representative _____

Date _____