Great Lakes Dental Solutions
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Consent for Treatment

I have been made aware of the diagnosis associated with my present dental condition and the proposed treatment options associated with this condition. I have been recommended dental treatment on one or more teeth and have been made aware of the risks versus benefits of doing nothing and the same for several treatment options. I am aware that Medicine and Dentistry is not an exact science and no guarantees of success or results have been made. I understand that Specialist(s) referral may be required for any complications arising during and or after completion of treatment. I shall be responsible for all costs associated with any specialist referrals and or ER Hospital visits.

I consent to the administration of local anesthesia, antibiotics, analgesics, or any other drug that may be deemed necessary in my case, and understand that there is a small element of risk inherent to the administration of any drug or anesthesia. The risks can include adverse allergic reaction including anaphylaxis, vomiting, miscarriage, cardiac arrest or even death, aspiration, irritation and swelling of a vein, pain, discoloration and injury to blood vessels and/or nerves.

I have been made aware that tobacco, alcohol and recreational drug use could lead to failure of desired outcome.

I have been made aware of the possible risks, but not limited to - pain; infection; swelling; bruise; bleeding; discomfort; headache; muscle stiffness or trismus; cheek and or lip bite; cracking or redness of corner of lips; teeth and gum irritation and recession; chipping or damage to adjacent teeth, restorations or other oral structures; lip numbness; discoloration of teeth and gums; foul odor; altered taste; sub-luxation and dislocation of teeth and or TM joint; and jaw bone fracture.

(A) Extraction and surgical procedures: Possibility of dry socket that may occur following surgery (loss of blood clot); altered nerve sensation on lip and chin including numbness, tingling, itching or burning that may last for few weeks to months or even result in permanent lip numbness; communication of oral cavity with the sinus is possible, requiring a surgical repair by specialist. In rare cases, tooth root maybe left behind to prevent damage to nerve and critical structures. Bone grafting maybe required providing support to adjacent teeth or critical structures. Sharp bony splinters may require additional surgery.

(B) Root canal treatment: Darkening of tooth after case completion; tooth perforation; root resorption; risks associated with irrigation solution; and on rare occasion breakage of instruments requiring specialist referral or may remain wedged inside the tooth and sealed; possibility of blocked canals and previously treated tooth may fail requiring re treatment or tooth removal and. A permanent filling and crown has been advised to prevent breakage of tooth.

(C) Gum or periodontal treatment: I have been made aware of the gum / periodontal disease that are currently affecting my teeth and gums and the resulting loss of bone. Deep cleaning can cause recession of gums and exposure of root surface of teeth; increased spacing between teeth; increased teeth sensitivity; loosening of teeth; food impaction between teeth.

(D) Partial or complete denture: I understand that bone loss will continue to occur due to loss of internal stimulation; breakage of plastic portion of denture/ tooth, popping of tooth from denture base may occur. Immediate denture will require reline or new set of denture.

(E) *Fillings and crown and bridge:* Varying degree of sensitivity is expected after treatment and it does not prevent future tooth decay or gum disease. Shade will be selected by patient and will be matched as close as possible to existing teeth or restorations.

(F) *Orthodontic treatment:* Treatment does not guarantee perfectly straight teeth and requires routine retainer use. Root resorption or shortening of root may occur.

(G) *Photographs*: I authorize Doctor and staff to take pictures and/or videos of my face, jaws and teeth before, during and after treatment and give my consent to post them on online and/or print for marketing, education, publications, research and records. No compensation financial or otherwise is expected from the use of photographs and videos.

☐ Use pictures or videos for my records only, do not post any pictures or videos on website or social media.

I will follow pre-operative and post operative instructions as advised by the staff and/or the doctor and I understand it is my responsibility to contact the office promptly in case of any undue circumstances that occur post treatment.

I do voluntarily assume responsibility for 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.

I hereby certify that I have provided accurate and complete medical history including past and present medical and dental conditions, prescription and non prescription medications, any allergies, recreational drug use and pregnancy status (if applicable). I have had sufficient time to read and understood the above in English and all questions have been answered. I hereby give consent to the dental procedure(s) performed and am aware of the known risks, advantages and disadvantages of alternative treatment options.

Patient Name: _____

Patient / Legal guardian Signature: _____ Date: _____