

**GENERAL DENTISTRY
INFORMED CONSENT
FOR THE OFFICE OF
JEFF HIBBARD, D.D.S.**

Name _____

1. WORK TO BE DONE

I understand that I am having the following work done:

- Fillings Bridges Crowns
 Extractions Denture/Partial Other _____

2. I understand that I am financially responsible for the entire cost of treatment once begun. If, for any reason, I do not keep my appointments to complete the case I understand that I will be billed at Dr. Hibbard's usual and customary hourly rate to reimburse him for his costs and care. (INITIALS _____)

3. DRUGS AND MEDICATIONS

I understand that anesthetics, antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, anaphylactic shock (severe allergic reaction), and/or cardiac or pulmonary arrest. I understand that the needle may separate during the injection and further treatment would be needed by an oral surgeon. (INITIALS _____)

4. CHANGES IN TREATMENT PLAN

I understand that my treatment plan may change and procedures may be added or removed from my case because of discovery of a condition that was not obvious or could not be recognized at the time of the initial examination. A common example of this is the necessity for root canal therapy following routine restorative procedures. I give my permission to make any/all changes. (INITIALS _____)

5. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, implants, partial dentures, bridges, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #4. 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, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue which may be temporary or permanent, loss of bone structure, perforation of the sinus, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (INITIALS _____)

6. CROWNS AND BRIDGES

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered or the permanent crown may not fit. The temporary crown is only designed to stay on for 2-3 weeks. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size, and color) will be before cementation. If I do not return for my scheduled cementation appointment, and I delay treatment, the crown might have to be remade, the cost of which is my responsibility. (INITIALS _____)

7. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, acrylic, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I have been given the option of implant dentistry. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be at the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (INITIALS _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature _____ Date _____

Doctor _____ Witness _____