INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

THE DENTAL OFFICE ENCINO
17071 VENTURA BLVD, ENCINO

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefit and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered, By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentist or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, or any other serious condition, advise your dentist immediately so he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a wonal on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dentist for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and might result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dentist, I the patient/guardian and/or my representative agree not to advance,directly or indirectly, any false, meritless, and/or frivolous claim(s) of dental malpractice against dentist.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use board-certified witness(es) in the same specialty/field as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the CDA.

In an effort to control the increasing costs of dental care, any claims or disputes against this office shall be resolved by "binding arbitration." By signing this agreement, the patient agrees with the office of the Dental Office of Encino, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement including associates) shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal results. Even though many of these complications are rare, they can and do occur occasionally.
Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment

2. Infection in need of medication, follow up procedures or other treatment
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restoration, gums or soft tissue
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or peice of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or need for further treatment
12. Allergic reaction to anesthetic, medication or dental materials
13. Need for a follow up treatment, including surgery

This form is intended to provide you with an overview of potential risks and complication. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss these potential benefits, risks and complications of recommended treatment with all options with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentists before commencing treatment.

_____ _____

Patient's SIgnature Date

_____ _____

Print Patient's Name Parent/Legal Guardian