# DR VIRAL I PATEL

**BDS MDS [PERIODONTOLOGY]**
***REG NO:- A-1650***

**Informed Consent Form**

This information is provided to help you understand the treatment I am recommending for you. Before I begin treatment, I want to be certain that I have provided you with enough information in a way you can understand, so that you're well informed and confident that you wish to proceed. This form will provide some of the information. I will also have a discussion with you.
PLEASE BE SURE TO ASK ANY QUESTIONS YOU WISH. It's better to ask them now, than wonder about it after we start the treatment.
Nature of the Recommended Treatment:-_____________________________________________________________
I am recommending the following treatment(s) for you:
______________________________________________________________________________________________
I base this recommendation on the visual examination(s) I have performed, on any x-rays, models, photos and other diagnostic tests I have taken, and on my knowledge of your medical and dental history. I have also taken into consideration any information you have given me about your needs and wants. The treatment is necessary because:
_____________________________________________________________________________________________

The benefits of this treatment are: __________________________________________________________________

The prognosis, or chance of success, of the treatment is:
___________________________________________________________________________________________

I expect that it will take approximately ______________________to complete the treatment, but it could be shorter or longer based on what we experience as the treatment progresses. I expect it to cost about Indian Rs ______________ and I will let you know as soon as possible if the cost estimate increases or if it can be reduced.
If you have any questions about these alternatives, or about any other treatments you hove heard or thought about, please ask.

***Risks Of The Recommended Treatment***
No dental treatment is completely risk free. I will take reasonable steps to limit any complications of the treatment I have recommended. However, there are some complications that tend to occur with some regularity. These include:
_______________________________________________________________
If you have any questions about these complications, or about any other complications you have heard or thought about, please ask. I believe that the treatment will be most successful when you understand as much as possible about it, because you will be able to provide more information to me and to ask better questions. No question is too simple to ask and I have as much time to answer them as you need. When you feel you can make on educated decision about this recommendation, then we can get started with treatment.
Acknowledgment
I_____________________________________, have received information about the proposed treatment. I have discussed my treatment with Dr.________________________ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.
I wish to proceed with the recommend treatment.

Patient Name:- ________________________________________ Age:- ________

Patient or Guardian Signed:- ______________________ Treating Dentist Signed:-______________________

Witness Name & Signed:- __________________________ Date:- _______________

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**General Dentistry Informed Consent Form**

***Treatment Plan***
I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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. For example, root canal therapy following routine restorative procedures.

***Drug and Medications***
I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

***Extractions***
Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc.) I understand removing teeth does not always remove the infection, if present, and 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 (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

***Crown's, Bridges, Veneers***
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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, 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 delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

***Endodontic Therapy***
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to restore it.

***Periodontal Disease***
I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

***Fillings***
I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays I understand that significant sensitivity is a common after effect of newly placed fillings.

***Partials And Dentures***
I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

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

Patient Name & Signed:-_________________________________ Date:- _________________

Treating Dentist Signed:- _________________________________ Date:- _________________

Witness Name & Signed:- ________________________________ Date:- _________________

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**Health Questionnaire Acknowledgment and Consent to Proceed**

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent
appointment.

I authorize Dr.______________________________________ and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended
period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Name & Signature of patient / legal guardian / authorized agent of patient:-

Treating Dentist Signed:- ___________________________________________ Date:- ______________________

Witness Name & Signed:- __________________________________________ Date:- ______________________

# DR VIRAL I PATEL

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***REG NO:- A-1650***

**CONSENT FOR DENTAL SURGERY**

Patient Name_________________________________________Date of Birth_________________________
I hereby authorize Dr.______________________________, and any other dentists of ____________________ to perform the following treatment or surgical procedure____________________________________, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
2. Resticted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Postoperative infection requiring additional treatment.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Damage to adjacent teeth, fillings, and crowns.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

(     ) I consent to the administration of **local anesthesia, nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above (circle all that apply).

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medications.

Patient Name & Signed:-__________________________________ Date:- _________________

Treating Dentist Signed:- _________________________________ Date:- _________________

Witness Name & Signed:- _________________________________ Date:- _________________

# DR VIRAL I PATEL

**BDS MDS [PERIODONTOLOGY]**

***REG NO:- A-1650***

**CONSENT FOR ENDODONTIC (ROOT CANAL) SERVICES**

Patient Name____________________________________Date of Birth____________________________
I hereby authorize Dr. ______________________________, and any other dentists of _______________ to perform an endodontic (root canal) procedure on tooth (teeth) _#_________________________________, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Root canal therapy is indicated when the pulp chamber of a tooth is contaminated by bacteria causing the canals to become infected. The procedure is accomplished when the dentist creates a small opening in the biting surface of the tooth that will allow it to be disinfected and then sealed with an inert rubber-like substance. The sealing of the canals prevents subsequent passage of bacteria into or out of the tooth.

I have been informed that the risks to my health if this procedure is not performed may include, but are not limited to: increased pain, swelling, loss of the tooth (teeth), loss of other teeth nearby, loss of the supporting bone, spreading infection, cyst formation, and/or deterioration of general health due to systemic infection.

I have been informed of possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

- A failure to completely eliminate the infection requiring retreatment, root surgery or removal of the tooth at a later date;
- Post-operative pain, swelling, bruising, and/or limited jaw opening that may persist for several days;
- Separation (breakage) of an instrument within the canal during treatment. Broken instrument tips are typically allowed to remain in the canal, and only rarely are they the cause of subsequent problems. If removal is indicated the patient may be referred to an endodontic specialist.
- Perforation of the root from within the canal can occur requiring additional treatment by a specialist. Such complications will occasionally result in the loss of the tooth.
- Damage to nerves supplying the teeth resulting in temporary or, in rare instances, permanent numbness or tingling of the lip, chin, or other areas of the jaws or face:
- Inability to adequately clean the canal(s) due to unforeseen calcified obstructions or severely bent roots. Under certain circumstances the patient may be referred to a specialist for successful completion of the procedure. Loss of the tooth may occur:
- A fracture of the treated tooth, occuring during or after endodontic treatment. Treated teeth sometimes break due to the tooth's loss of strength resulting from the procedure. In most cases a crown is recommended after treatment to prevent such an occurrence.

Once treatment has begun, it is essential that it be completed in a timely manner. Root canal treatment will require from 1-5 appointments. Also, I understand that successful treatment does not prevent future decay or fracture of the treated tooth.
I understand the recommended treatment, the risks of such treatment, alternative treatments should any exist, and the consequences of doing nothing.

Patient's Signature___________________________________________________ Date_________________

Parent or Legal Guardian Signature_____________________________________ Date_________________

Dentist's Signature___________________________________________________ Date_________________

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***IMPLANT PATIENT INFORMATION AND CONSENT FORM***

***1.*** I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.
***2.*** My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.
***3.*** I have further been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.
***4.*** I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing. In addition, I am aware that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.
***5.*** My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.
***6.*** It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made. I am aware that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with the removal.
***7.*** I understand that excessive smoking, alcohol, or blood sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
***8.*** I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
***9.*** To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
***10.*** I consent to photography, filming, recording, x-rays and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.
***11.*** I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedures.

Patient's Signature_______________________________________________ Date_______________

Parent or Legal Guardian Signature_______________________________ Date_______________

Dentist's Signature_______________________________________________ Date_______________

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***PREDICTABLE FACTORS THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT:***

***Cooperation***: In the vast majority of orthodontic cases, significant improvement can be achieved with the patient's cooperation.

***Caring for Appliances***: Poor brushing increases the risk of decay when wearing braces. Excellent oral hygiene, reduction in sugar, being selective in diet, and reporting any loose bands as soon as noticed, will help minimize decay, white spots, (decalcification), and gum disease/problems. Routine visits every 3-6 months to your dentist for cleaning and cavity checks are vital during treatment!!!

***Appointments Must be Kept***: Missed appointments create many scheduling problems and lengthen treatment time.

***UNPREDICTABLE FACTORS THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT***: .

***Muscle Habits***: Mouth breathing, thumb, finger, or lip sucking, tongue thrusting, (abnormal swallowing), and other unusual habits can prevent teeth from moving to their corrected positions or cause relapse after braces are removed. .

***Facial Growth Patterns***: Unusual skeletal patterns and insufficient or undesirable facial growth can compromise the dental results, affect a facial change and cause shifting of teeth during retention. Surgical assistance may be recommended in these situations. .

***Post Treatment Tooth Movement***: Teeth have a tendency to shift or settle after treatment as well as after retention. Some changes are desirable; others are not. Rotations and crowding of the lower front teeth or slight space in the extraction site are common examples. .

***Tempomandibular Problems, (TMJ):*** Possible TMJ or jaw joint problems may develop before, during, or after orthodontic treatment. Tooth positions, bite, or pre-existing TMJ problems can be a factor in this condition. .

***Impacted Teeth***: In an attempt to move impacted teeth, (teeth unable to erupt normally), especially cuspids and third molars, (wisdom teeth), various problems are sometimes encountered which may lead to periodontal problems, relapse, or loss of teeth. .

***Root Resorption***: Shortening of root ends can occur when teeth are moved during orthodontic treatment. Under healthy conditions the shortened roots are usually no problem. Trauma, impaction, endocrine disorders, or idiopathic, (unknown), reasons also cause this problem. Severe resorption can increase the possibility of premature tooth loss. .

***Nonvital or Dead Tooth***: A tooth traumatized or other causes can die over a long period of time or without orthodontic treatment. This tooth may discolor or flared up during orthodontic treatment. It could deteriorate during treatment causing loss of bone around the teeth. Excellent oral hygiene and frequent cleanings by your dentist can help control this situation. .

***Unusual Occurrences***: Swallowing appliances, chipped teeth, dislodging restorations. I consent to the taking of photographs and x-rays before, during and after treatment and to the use of same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved, and do consent to orthodontic treatment.

Patient's Signature_______________________________________________________ Date_________________

Parent or Legal Guardian Signature_____________________________________ Date_________________

Dentist's Signature_______________________________________________________ Date_________________

***Consent For Removal Of Braces / Appliance:-***

Patient's Signature_______________________________________________________ Date_________________

Parent or Legal Guardian Signature_____________________________________ Date_________________

Dentist's Signature_______________________________________________________ Date_________________