Consent for Dental Services

LABEL

Name/DOB:

This information is provided to by Southern Nevada Health District (SNHD) help you better understand treatment recommendations. Prior to consenting to treatment, you should carefully consider the benefits and risks of the recommended treatment plan. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications. It is very important that you provide your dentist with accurate information before, during, and after treatment. Please ask for assistance if you have any additional question or need further explanation about the information below.

Please read and initial the items below and sign at the bottom of the form.

_____ I give consent for a public health dental hygienist to perform a dental screening/assessment to determine a dental hygiene are plan for my current condition. I understand that the screening/assessment does not replace a full comprehensive dental examination, (including X-rays) by a licensed dental provider. I understand that I should still have a comprehensive dental examination completed at my dental home.

_____ I give consent for a gum evaluation and/or a professional dental cleaning with specialized instruments to remove plaque, calculus (tartar) and bacteria from the tooth, root planing (smooth and contour the root surfaces) and removal of any dead tissue to clean out the gum pocket. I understand that depending on my current dental/medical condition or medications, these methods alone may not completely reverse the effects of gum disease or prevent further problems. I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface causing teeth to become more sensitive to hot/cold or become looser. I understand that every reasonable effort will be made to ensure that my condition is treated properly.

_____ I give consent for application of fluoride to reduce the risk of dental caries. The fluoride preparation used is a stronger concentration than that in toothpastes/fluoride mouth rinses that are available over the counter. Professional fluoride treatments are administered in the form of a solution, gel, foam or varnish. Following the application, rarely there is swelling in the mouth or nausea in those that have sensitive stomachs.

_____ Dental sealants are a thin plastic coating that are applied to the chewing surface of teeth to prevent cavity-causing bacteria from getting into naturally occurring grooves of the teeth. I understand that although care and diligence will be exercised during application, there may be unsuccessful results and/or failure of the sealant. I understand that a sealant may loosen of become dislodged overtime and may need to be re-applied. The life of the sealant is uncertain and may be affected by chewing forces, diet, and/or inadequate oral hygiene. Although rare, products used during the application process may have a reaction with the mouth tissue that may include burning, itching, swelling or redness.

_____Routine follow-up cleanings are important to control the bacteria that cause periodontal (gum) disease. I understand that if continuing care treatment is interrupted or discontinued, my periodontal condition can continue to worsen. This could lead to further inflammation and infection of gum tissue, tooth decay, deterioration of bone surrounding the tooth and eventually, the loss of teeth.

_____I understand that a topical anesthetic may be applied depending on the sensitivity of the area(s) to be treated. Although rare, these anesthetics may have a reaction with the tissue that includes burning, itching, swelling or redness.

_____ Although the use of local anesthetics to control pain is a safe, well-established procedure, adverse reactions and complications can occur. These reactions include, but are not limited to, the following: fainting, rapid heartbeat, hyperventilation, toxicity or allergic reaction. I understand that it is my responsibility to inform the dental provider of any pre-existing medical conditions or medications that may interact with the local anesthetic. I understand that complications can arise from the injection itself which include, but not limited to, the following: numbness, paraesthesia (temporary nerve damage), hematoma (bruising), trauma, and pain. I understand that the local anesthetic may be administered by a public health dental hygienist under the supervision of a dentist (DDS/DMD), medical doctor (MD/DO), or physician's assistant (PA-C).

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_____ I understand that professional products may be applied to sensitive areas of the teeth and/or gums to improve discomfort. Although usually highly effective, more than one treatment may be necessary to improve condition.

_____If applicable, I consent to the use of professional tools and solutions to aid in the cleaning of partials and/or dentures. I will notify the provider if my prosthetic has existing damage so that special precautions can be taken to prevent further harm.

_____I understand that a home care routine will be established and taught to me by a member of the dental team. The success of the treatment depends in part on my efforts to brush, floss and use other aides daily, receive professional cleanings as directed, follow a healthy diet and avoid tobacco products or drugs.

Please sign below:

I understand that no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the condition(s) listed above. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information, and that all of my questions have been answered to my satisfaction.

Patient/Guardian Signature: _____ **Date:** _____