Repscher Dental
682 S. Ferguson Ave. Suite #3
Bozeman, MT 59718

Informed Consent

(406)-522-8801

This is my consent for treatment as previously explained to me, or other procedures deemed necessary or advisable to complete the planned dental procedures or therapies.

I understand that the purpose is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) diseases, dental decay, malocclusion, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that such operative risk include, but are not limited to the following:

1. Post operative discomfort and swelling that may necessitate several days of home recuperation
2. Bleeding that may be prolonged
3. Injury to adjacent teeth, caps, or fillings
4. Post-operative infection, requiring additional treatment
5. Stretching of the corners of the mouth with resultant cracking and bruising
6. Restricted mouth opening for several days or weeks
7. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently
8. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
9. Minor scarring on the gingival (gums) recession and exposure of root surfaces that may occur after treatment
10. Some amount of gingival (gums) recession and exposure of root surfaces that may occur after treatment
11. A change in my bite or the way my teeth came together
12. A difference in the appearance of my face and/or teeth
13. Temporary restorations may loosen and come out of the mouth requiring replacement
14. Temporary treatment is temporary and more definitive treatment will have to be done at a later date
15. Sensitivity of the teeth may result in the placement of restorations and temporaries and my persist for several days, weeks, or months
16. Sores may appear on soft tissues beneath newly placed removable full and partial dentures necessitating adjustment of the appliance(s)
17. Removable dentures may become progressively looser after initial placement and require re-fitting or re-lining
18. Teeth may fracture due to undetectable cracks being present at the time of restoration, requiring additional treatment
19. Teeth may become necrotic after treatment due to undetectable infection, fractures, or trauma at the time of initial treatment requiring endodontics therapy or extraction of the infected tooth (teeth)
20. Crowns, bridges, restorations, veneers, removable prosthetics, implants, and any other artificial appliances or materials in the mouth may become defective at any time for reasons not attributable to the dentist or staff

Medications, drugs anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs: thus, I have been advised not to work or operate any vehicle, automobile, or hazardous device for at least twenty-four (24) hours after my release from surgery or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

If any unforeseen condition should arise in the course of the treatment calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

No guarantee or assurance has been given me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss the treatment and my past medical and dental history including any serious problems and/or injuries.

I agree to cooperate completely with the recommendation of the doctor while I am under his care, realizing that any lack of the same could result in a less-than-optimal result.

I certify that I have had an opportunity to read and fully understand the terms and works within the above consent to the treatment and the explanation referred to or made, and that all statements and inapplicable paragraphs, if any, were stricken before I signed, I also state that I read and write English, or that this consent had been fully explained to me in my native language.

_____	_____	_____
Patient, Parent, or Guardian	Witness	Date