

Spencer Creek Dental Care
Dr. Monroe M. Ginsburg Dr. Mahamid A. Khan

Consent for Dental Treatment

I, _____ do hereby give consent to the performance of dental procedures by Doctors Ginsburg and Khan and their staff.

I authorize the taking of photographs, x-rays, any other records as is deemed necessary for use by Spencer Creek Dental Care, its doctors and staff, or any entity authorized by Spencer Creek Dental Care. I acknowledge that all original records and diagnostic aids are the property of Spencer Creek Dental Care. Copies may be furnished upon written request based on established policies of the office. There may be a fee for duplication and/or transfer of records.

I consent to administrations of local anesthesia and other drugs deemed necessary in my case and understand the risks of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/ or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetic.

I authorize the evaluation, diagnosis and performance of restorative procedures and/or other dental procedures deemed necessary or advisable by Doctors Ginsburg and Khan including the administration of local anesthesia and/or nitrous oxide.

General Procedure Categories:

I understand that during the course of treatment, conditions not evident during the examination process may necessitate procedures different from those planned and I may need a specialist for necessary treatment. I therefore authorize the doctors to perform such additional procedures or treat unhealthy or unforeseen conditions that may be encountered, as they may seem necessary or desirable during treatment after I have been consulted. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

I understand local anesthetics will be used in most dental treatments. I further understand that side effects of dental injections and anesthetics may cause soreness at the injection site, a temporary rise in heart rate, allergic reactions, and swelling. I understand that I should not eat while my lips, cheeks or tongue are still numb due to the risk of those areas and causing serious injury.

FILLINGS: I understand that my teeth may need new or replacement fillings. Certain side effects can include hot, cold, and/or biting sensitivity (pressure). Large cavities or pre-existing fillings may require root canal treatment may be required immediately after treatment of a tooth or after a period of time after the treatment is completed due to the effects of tooth decay and fillings on the nerves of the teeth. Crowns may be required to strengthen my tooth/teeth to decrease the risk of future tooth fracture. I understand it may not be possible to match the color of natural teeth exactly with artificial filling materials. I understand that occasionally a "high spot" may be present after the numbness has worn off. If this occurs, please contact our office immediately for an adjustment of the "high spots".

CROWNS/BRIDGES/VENEERS: I understand that these procedures usually require two appointments. I may have a temporary restoration covering my tooth/teeth, which may come off easily, and that I must be careful to ensure the temporary is kept in place until the final custom restoration(s) are placed. I will contact the office immediately if the temporary comes off or breaks. Teeth can shift position without a temporary in place and could adversely affect the fit of the final restoration. I further understand that sometimes it is not possible to match the color of natural teeth exactly with cosmetic dental materials. I understand the final opportunity to make changes in my new crowns/bridges/veneer sin color, shape, fit or size occur before cementation. I realize that some crowns/ bridges/ veneers are used to treat decay and fracture and therefore, root canal therapy may be required during or after treatment if symptoms arise.

NO TREATMENT OPTION: I understand a treatment option is to receive no treatment. I also understand that I have a right to refuse any treatment Drs. Ginsburg and /or Khan recommend by signing a separate refusal of treatment consent form consisting of risks of no treatment. I further understand that unwillingness to sign a refusal of treatment form or refusal of multiple recommended treatments could lead to dismissal from the office of Spencer Creek Dental Care.

DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I will keep my doctor informed of all current medications that I am taking and any allergies that I may have. Certain medications may cause drowsiness and it is not recommended to drive, drink alcohol or operate hazardous equipment when using such drugs.

The nature and risks of these procedures have been fully explained to me and I understand them. I will have sufficient opportunity to discuss my dental condition/problem(s), the treatment plan, anesthesia procedures, and the benefits to be reasonably expected from these treatments/procedures, compared with alternative approaches and/or no treatment. I recognize that the practice of dentistry is not

an exact science and that no guarantees have been made to me concerning the result of these procedures I have requested and authorized.

Doctors Ginsburg and Khan reserve the right to discontinue treatment if, in their opinion, circumstances justify such action. Among reasons for discontinuation of treatment are repeated lateness and failure to keep appointments.

All of my questions have been answered to my satisfaction and I consent to treatment.

I further consent to the release of dental treatment x-rays, and additional information which would be required by another dentist, insurance company, or agency of dental care quality review

I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have requested authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with the doctors at Spencer Creek Dental Care, their associates or assistants and that I understand the information provided.

I acknowledge I have received Spencer Creek Dental Care's Notice of Privacy Practices.

Patient's Printed Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____