INCREDIBLE Smiles™

Consent to Dental Treatment

This informed consent and authorization is given to Dr. Priya Uppal, Dr Lori Kemmet, or any associates of Incredible Smiles, after having first had a full explanation of the nature of the proposed treatment, the alternatives, and the risks. Doctor has advised me that from the full dental examination received, I have the following condition(s):

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______ I fully understand and accept my diagnoses and my condition(s).

Treatment: I hereby authorize and consent to Doctor and whomever the Doctor may designate, to perform the following procedure(s):

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______ I fully understand and accept this as my voluntarily chosen treatment plan.

Alternative Treatments: In making the above recommendation(s), Doctor has advised me that alternative treatments exist which may include, but are not necessarily limited to: nonsurgical therapy, surgical curettage of cleaning, tooth extractions, implant treatments, and any other described as follows:

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______ I fully understand my alternative treatments and have, however, elected to treat my condition by the proposed treatment, rather than any alternative treatments.

Non-treatment Risks: Doctor has advised me that no treatment is also an alternative. If this condition persists and is not corrected, the risks may include, but are not necessarily limited to: premature tooth loss, need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infection, pain, poor chewing, tooth sensitivity, tooth movements, worsening of the periodontal disease condition, deeper pocketing, and other described as follows: ______________________________

______ I fully understand the non-treatment risks.

Treatment Risks: I fully understand that inherent to any procedure, and because of an individual's variations, certain risks are involved with this treatment. These may include, but are not necessarily limited to: swelling, pain, hot or cold tooth sensitivity, gum recession, tooth mobility, food impaction, **root canal therapy**, **nerve problems**, joint pain or disorder, bleeding, and/or adverse reaction to local anesthetics. Any additional root canal fees are not the financial responsibility of Incredible Smiles.

______ I fully understand and accept the risks associated with my treatment.

I understand that for successful treatment results and to lessen the dangers of complication, the following treatment conditions are required of me: compliance with my individual maintenance program, excellent oral hygiene, and cooperation in keeping appointments. Other precautions and recommendation may include, but are not necessarily limited to: ______________________________

______ I fully understand and accept all precautions and recommendations for my chosen treatment.

I have received a full and complete opportunity to ask questions about the proposed treatment and all questions asked have been answered to my complete satisfaction before signing this form. I affirm that I understand the nature of my treatment, the alternative to my treatment, the risks of non-treatment, and the risks of my treatment and with that full understanding accept the treatment plan stated above. I further acknowledge that all blanks on this form requiring completion have been filled in or deleted, if necessary, prior to my signing this form as evidenced by my initials below each blank. My signature on this form indicates and is proof that I have given informed consent for the treatment of my conditions in the manner specified herein.

______________________________	____________	______________________________
Signature of guest or guardian	**Date**	**Print Name**
______________________________	____________	______________________________
Doctor signature	**Date**	**Print Name**