PATIENT INFORMATION AND CONSENT FORM

This document is TWO pages. Please read it carefully, with ALL of the other attached documents provided. Please ensure you fully understand the information and informed consent. You will be required to sign at the bottom of each of the two pages and return it back to our office prior to initiation of the indicated treatment, however, it does NOT commit you to treatment. Please do not hesitate to contact us should you have any questions prior to signing. You can request to repeat the consultation, case presentation, have further discussion and ask more questions before the treatment.

Dear .....,

We strongly believe in the principle that good communication is the heart of excellent dental practice and it has long been recognised as it provides patients with information that enables them to make informed decisions about their dental care. We ask you to read the following information, consent form and attached documents related to your dental condition, so that we can share with you some facts about your dental treatment, which like any medical or dental treatment, includes some limitations and risks. We also ask you to read the Australian Dental Association patient information guides and brochures that have been issued to you after your case presentation and discussion at our practice. This information is routinely supplied to anyone considering dental treatment in our practice. It is our responsibility to discuss and provide each patient with information so that the patient has an understanding of the nature and extent of the problem, the nature of the treatment proposed, the benefits of treatment, the risks of treatment, treatment alternatives and possible consequences if no treatment is provided. These documents attempt to explain some of the potential problems that can arise as a result of dental treatment. It would be impossible here or anywhere else to exactly predict and mention every problem that could arise with dental treatment. Treatment of human conditions has not reached the state of absolute perfection despite technological advances and continuous scientific research. Dentistry is not a perfect science and, in dealing with issues such as growth/ development, genetics, stress, limitations of biomaterials, natural aging, microbial plaque, pathogens, immune response, limited accessibility of the oral environment and patient co-operation, achieving an optimal result is not always possible. We will make every effort to assist you during your treatment, and to keep you fully informed as to the progress of your dental treatment. Our treatment objectives are always to inform your decision and obtain the best possible result.

1. I have been informed and I understand: the nature of my dental condition, possible treatment options, rationale for each treatment option, possible complications and risk of failure. My dentist has carefully examined my mouth and recommended treatment options. Alternatives to these treatments have been explained to me in details, including - but not limited to - no treatment or referral to a specialist. I have considered all the alternatives, but I consent to proceed with the recommended treatment at A1Dental.

2. I have further been informed of the possible complications, risk of failure and biological implications involved with the dental procedures, treatment and anesthesia. Such complications including - but not limited to - pain, swelling, infection, discoloration. In extremely rare case prolonged or permanent numbness of the: lip, tongue, chin, cheek, or teeth may occur as a result of a local anesthesia. Also, possible are inflammation of a vein, injury to teeth and/or surrounding structures (example: sinus, tongue, joint, facial muscles) persistent pain, anaphylaxis, allergic reactions to local anesthesia, drugs or medications used, etc.

3. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, fracture of teeth, loss of teeth. Also possible are temporomandibular joint (jaw) problems, headaches, referred pain to the back of the neck and facial muscles, and tired muscles when chewing.

4. It has been explained that in some instances dental treatment may fail. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of results of treatment can be made.

5. I understand that smoking, excessive sugar and/or acid consumed, acidic saliva, gastric reflux, lack of regular dental cleanings and poor brushing/flossing may affect the longevity of the treatment. I agree to follow my dentist's gum care instructions, including regular dental cleanings every 6 months. I agree to report to my dentist for regular examinations/recalls as instructed.

6. I understand that the dentist will choose the best-suited anesthesia for me based on the medical history information that I have supplied to the dental practice. I accept the type of the anesthetic the dentist has chosen on my behalf. I agree not to operate a motor vehicle or hazardous device while taking the prescribed pain medication or the antianxiety medication. I agree to take antibiotic medication as prescribed. I understand that the proposed treatment has been clinically trialed and is supported by scientific research. I understand that the indicated procedures have been utilized in dentistry for an extended period of time.

Patient's / Guardian's full name …… Date of birth ….. / …… / ……..

Patient's / Guardian's signature: …….. Date: ……/……/…….

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7. To my knowledge I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs (including anesthetics), blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

8. I consent to photography and video recording of the procedure to be performed for the advancement of dentistry and research/educational purposes, provided my identity is not revealed.
   (Please CROSS and insert your initials on number 8, if you do not give permission)

9. I understand that the medications, drugs, anaesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anaesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not smoke, consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

10. I understand that Dr …… …….. is a General Dental Practitioner, and NOT a specialist.

11. I, …… *(full name)* request and authorize medical/dental services for myself. I fully understand that during and following the contemplated procedure, conditions may become apparent which warrant, in the judgment of the dentist, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in designs, materials, or care, if it is felt this is for my best interest. I understand that unforeseen conditions may arise that require a procedure that is different than set forth above or a referral to a specialist. I authorize the dentist and any associates to perform such procedures when in their professional judgment, the procedures are necessary. I fully understand this consent form, and I have had the opportunity to question the dentist concerning the nature of treatment, the inherent risks of treatment, and the alternatives to this treatment. I agree to strictly follow the after-care instructions and the dental home care plan.

12. Documents provided (please tick).

	Patient information and consent form
	Dental Imagery for case presentation (photos and radiographs)
	Treatment plan, with item number(s), description and fees
	ADA reading-material(s) for patients
	Others, …… ……

This box is for Office Use ONLY	Date	Received / Scanned by
A1Dental Stamp	…. ….. …..	……

Patient's / Guardian's full name …… Date of birth ….. / …… / ……..

Patient's / Guardian's signature: …….. Date: ……/……/…….