Marna Mae Torre Longakit, DMD
Familiy Care Dentistry

CONSENT FOR TREATMENT

EXAMINATION AND X-RAYS
I understand that the initial visit may require radiograph in order to complete the examination, diagnosis, and treatment plan. Initial: _____

CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the initial examination, the most common being root canal therapy following routine restorative procedures, and adjacent tooth decay. I give my permission to Drs Longakit / Madayag to make any or all changes in addition as necessary. Initial:_____

DRUGS, MEDICATIONS, AND ORAL SEDATION
I Have been informed and understand that antibiotics and other medication can cause allergic reaction causing redness and swelling of tissue, pain, itching, vomiting, sunlight sensitivity,and or anaphylactic shock (for severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I full understand and agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of oral sedation and narcotic drugs that i took before any dental procedure. I understand that failure to take the necessary medications prescribed may offer risks of continued or aggravated infection, pain and potential resistance to effective treatment of my condition. I fully understand that antibiotics can reduce the effectiveness of contraceptives in general. Initial: _____

FILLINGS
I understand that sensitivity is a common side effect of a newly placed filling. That we may adjust the bite after discharge due to feeling of numbness after the filling procedure made. Initial: _____

PERIODONTAL TREATMENT
I understand that i have serious condition causing gum tissue inflammation and/or bone loss and it can lead to the loss of my teeth and affect any systemic diseases. Alternative treatment plans have been explained to me including no-surgical deep cleaning and root planning, gum surgery and /or extration/s. I understand the success of any treatment depends in part in my efforts to brush and floss daily (home care), receive regular checkups as directed, follow a healthy diet and follow other recommendations. Initial: _____

ENDODONTIC TREATMENT (ROOT CANAL THERAPY)
I understand that there is no guarantee that the root canal treatment will save my tooth/teeth, and that complications can occur from the treatment, and occasionally a post are cemented in the tooth or extended through the root which does not not necessarily affect the success of the treatment. I understand that an additional surgical procedure procedures may be necessary following the procedure (apiectomy- root apex amputation). Initial: _____

CROWNS, BRIDGE, VENEERS AND BONDING
I understand that there are times that it is not possible to match the color of my natural teeth with the artificial teeth. I am fully aware that a temporary crown will be fabricated after the crown preparation and that it may come off easily. That i must be careful to ensure that it is kept on until the permanent crown/s is delivered. That i have to call in office for an immediate re-cemtation at the event the crown comes off. I realized that the final opportunity to make changes in the new crown, bridges, or veneers (including shape, fit, size and color) will be made before cementation. It has explained to me that, in few cases, cosmetic procedures may result in the need for future root canal treatment, which is unpredictable and an anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily hygiene. Initial: _____

COMPLETE OR PARTIAL DENTURES
I understand that partial or complete denture/s are artificial, constructed of plastic,/porcelain and metal framework. That most common problem will be looseness of the appliance, soreness, and possible breakage. I am aware that the final changes with the appliance (including shape, fit, size color and placement) will be during the wax, framework, teeth try in. I understand that most denture will require a 3, 6, to 12 months reline after initial placement to improve denture stability. That the cost reline procedure is not included from the initial placement. Initial: _____

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REMOVAL OF TEETH (EXTRACTION)
Alternatives of removal have been explained to me (root canal therapy, crowns,/bridges, periodontal surgery), however I authorize Dr Longakit to remove the following teeth for any personal reason.I understand that removing teeth does not always remove all of the infection, if present, it may require other treatment. I understand the risks involved after ext ration are pain, swelling, spread of infection, dry socket, loss of feeling (paresthesia) of the lip, teeth tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment from a specialist or even hospitalization if complications may arise during or following treatment, the cost of which is my sole responsibility. Initial: _____

TEMPOROMANDIBULAR DYSFUNCTION (TMD)
I understand that symptoms of popping, locking, clicking and pain can intensify or develop in the mandibular jaw joint (near the ear) subsequent to routine dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need arise, I will be referred to a specialist for treatment and the cost my sole responsibility. Initial:_____

DENTAL MATERIALS FACT SHEET
i have received and real a copy of the dental materials fact sheet as required by law. Initial_____

I understand that the art of dentistry is not the exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I acknowledge the receipt of and understand post-operative treatment instructions and have given an appointment date to return.

Patient/Parent Signature: _____ Date:_____
(If patient is under 18, parent/guardian signature require)