INFORMED CONSENT FOR GENERAL DENTISTRY

NORTHERN VIRGINIA DENTAL SOLUTIONS
8292 OLD COURTHOUSE RD
UNIT B
VIENNA, VA 22182
Ph : (703) 893-1603
Email:

General Consent to Professional Treatment at the Dental Office

1. WORK TO BE DONE: I understand that I am having professional treatment rendered in the office of NORTHERN VIRGINIA DENTAL SOLUTIONS. To establish myself as a new patient, I agree to complete the necessary paperwork, provide identification, and present a copy of my insurance card. I consent to a review of my medical history, a visual exam, a consultation, radiographs, oral cancer screenings, and a health scan. If I choose to decline radiographs during my appointment, it will be because I have provided recent radiographs taken within the past year. If I refuse to take radiographs when recommended by the doctor, the doctor reserves the right to decline treatment or services, and I will be charged a $45 fee for a missed appointment. I understand that during my new patient comprehensive exam, a cleaning will typically be performed alongside the exam and x-rays. Depending on the treatment required, I may need to reschedule for additional procedures such as cleaning, debridement, or scaling and root planing on a separate day.

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics, and other medications can cause known, unknown or undisclosed allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

3. 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 examination. For example: root canal therapy following routine restorative procedures. I give my permission to my dentist educate, discuss and make any/all changes and additions as necessary.

4. FILLINGS: I understand that care must be exercised in chewing very crunchy and sticky foods on fillings to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that some sensitivity is a common after effect of a newly placed filling.

5. CROWNS, BRIDGES, AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the long term crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, and color) will be before cementation. It is also my responsibility to return for long term crown cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying long term crown cementation.

6. PERIODONTAL LOSS (TISSUE AND BONE): I understand that if I have a serious periodontal condition, causing gum inflammation or bone loss that it can lead to the loss of teeth. Alternative treatment plans have been explained to me, including scaling and root planing, referral to specialist, gum surgery, replacements, and/or grafting. I understand that refusing recommended treatment may have a future adverse effect on my periodontal condition.

7. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges.

I understand that dentistry is not an 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 hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees.

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Signature	*Print Name*	*Date*