PATIENT'S NAME: ----------

DR. MINA HAGHIRI
AMERICAN DENTAL CENTER
DENTAL TREATMENT CONSENT FORM

1. HEALTH INFORMATION
I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medications, allergies or illness are risk factors.

2. DRUGS, LATEX AND MEDICINES
I understand that **antibiotics** and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills.
Latex allergy can cause rashes and itching.
Epinephrine increases heartbeat and, depending on my health, may be dangerous to me.

3. NEEDLE STICK
If someone is inadvertently stuck with needle used on me, I consent to have blood drawn for analysis.

4. FILLINGS, CROWNS AND UN-ANTICIPATED ROOT CANALS
Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. ROOT CANALS CAN FAIL
Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. PORCELAIN CROWN, VENEERS, BONDING AND COSMETIC FILLINGS
Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. GUM TREATMENTS AND REQUESTING "JUST A CLEANING"
If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).

8. EXTRACTION AND SURGERY
I understand that all dental extractions or surgeries carry risks. Some are minor like a dry-socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.

9. FEE FOR ADDITIONAL OR SPECIALTY CARE
I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. LIMITATIONS OF INSURANCE COVERAGE
There are charges beyond what insurance will pay. (E.g. temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work). As a service to patients, this office will file insurance claims on patient's behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover.

11.48 HOURS NOTICE FOR CANCELLATION
I agree to give 48-hours notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office hours (or weekend) is **NOT** sufficient notice.

12. REQUESTING RECORD TRANSFERS
Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

13. HYGIENE APPOINTMENTS
If I am more than 15 minutes late for my cleaning appointment (or any other appointment), I will be expecting at least 30 minutes wait time or reschedule and pay a broken appointment fee.

14.X-RAYS
It is our office policy to keep the original x-rays in this office. If the patient requests x-rays, He/She will be given a paper copy of the x-rays, and if the patient wants the original x-rays there will be a charge to take new x-rays for the patient to take.

15.PRESCRIPTION
It is our office policy that there is a charge for the prescription being written for any patient that chooses not to have procedure done in our office the day of there appointment.It will be credit to you for 2 weeks to any procedure you have done in our office.If you do not come in the period of the 2 weeks your money is not guaranteed back to the patient.

16.REGARDING PAYMENT
It is our office policy that payment is required before any dental treatment is done in our office. If you make arrangements to pay in payments on a bi-weekly or monthly basis, If payment is not received on time, there will be a late fee charged to account.

I DO NOT EXPECT GUARANTEES IN DENTAL CARE.I HAVE READ THE ABOVE AND CONSENT TO THE TREATMENT.

Signature of patient or parent of minor witness----------DATE:----------

AMERICAN DENTAL CENTER
2936 VALLEY VIEW LN.
DALLAS, TX 75234
(972) 214-4433

GENERAL DENTISTRY CONSENT FORM

NAME: _____ DATE: _____

1. WORK TO BE DONE: (INITIAL EACH PROCEDURE):
I UNDERSTAND THAT I AM TO HAVE THE FOLLOWING WORK DONE:

___LOCAL ANESTHESIA ___ROOT CANAL ___POST BUILD-UP ___BRIDGES
___GUM THERAPY ___CROWNS ___EXTRACTION(S) ___FILLINGS
___IMPACTED TEETH REMOVAL/ ORAL SURGERY ___OTHER_____

2. DRUGS AND MEDICATION: I UNDERSTAND THAT MEDICATION CAN RARLEY CAUSE ALLERGIC REACTIONS, WHOSE SYMPTOMS CAN INCLUDE, BUT ARE NOT LIMITED TO: REDNESS AND SWELLING OF TISSUES, PAIN, ITCHING, VOMITING, AND/OR ANAPHYLACTIC SHOCK (SEVERE ALLERGIC REACTIN). I ALSO UNDERSTAND THAT LOCAL ANESTHESIA INVOLVES RISKS AND HAZARDS SUCH AS POST-OPERATIVE SORENESS, TRISMUS (PROLONGED MUSCULAR SPASM), ALLERGIC REACTION, RESPIRATORY PROBLEMS, PARALYSIS, BRAIN DAMAGE OR EVEN DEATH.
INITIALS _____

3. CHANGES IN TREATMENT: 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. CHANGES OR ADDITIONS IN TREATMENT WILL BE APPROVED BY ME BEFORE FURTHER TREATMENT IS RENDERED.
INITIALS _____

4. ORAL SURGERY/ REMOVAL OF TEETH: ALTERNATIVES TO REMOVAL/SURGERY HAVE BEEN EXPLAINED TO ME (ROOT CANAL THERAPY, CROWNS, BRIDGES, AND PERIODONTAL SURGERY, ETC.), AS WELL AS THE HAZARDS AND CONSEQUENCES OF NON-TREATMENT. I AUTHORIZE DR. MINA HAGHIRI TO PERFORM THE FOLLOWING _____. I UNDERSTAND THAT TOOTH REMOVAL/ SURGERY DOES NOT ALWAYS REMOVE ALL OF THE INFECTION, IF PRESENT, AND IT MAY BE NECESSARY TO HAVE FURTHER TREATMENT. I UNDERSTAND THE RISKS INVOLVED IN HAVING TEETH REMOVED, SOME OF WHICH ARE BRUISING, PAIN, SWELLING, SPREAD OF INFECTION, DRY SOCKET, LOSS OF FEELING IN MY TEETH, LIPS, TONGUE, AND SURROUNDING TISSUE (PARESTHSIA) ALTERNATION OF TASTE OR FRACTURED JAW. I AUTHORIZETHE DENTIST TO MAKE THE DECISION DURING SURGERY TO LEAVE A SMALL PIECE OF TOOTH ROOT IN THE JAW WHEN ITS REMOVAL WOULD REQUIRE EXTENSIVE SURGERY AND WHEN POSSIBLE DAMAGE COULD OCCUR WITH REMOVAL. I UNDERSTAND I MAY NEED FURTHER TREATMENT BY A SPECIALIST OR EVEN HOSPITALIZATION IF COMPLICATIONS ARISE DURING OR FOLLOWING TREATMENT, THE COST OF WHICH IS MY RESPONSIBILITY.
INITIALS _____

5. CROWNS, BRIDGES, AND CAPS: I UNDERSTAND THAT WITH CRACKED OR FRACTURED TEETH, THERE CAN BE PULP (NERVE) DAMAGE TO THE TOOTH. AFTER THE CROWN PLACEMENT THERE CAN BE SENSITIVITY TO COLD, BITING PRESSURE, AND TENDERNESS TO THE GUMS. THE CRACKED TOOTH MAY POSSIBLY ABSCESS, NEEDING ROOT CANAL TREATMENT, OR IT MAY SPLIT AND NEED TO BE EXTRACTED. I UNDERSTAND THAT SOMETIMES IT IS NOT POSSIBLE TO MATCH THE COLOR OF NATURAL TEETH EXCATLY WITH ARTIFICAL TEETH. I FURTHER UNDERSTAND THAT MAY BE WEARING TEMPORARY CROWNS, WHICH MAY COME OFF EASILY AND THAT I MUST BE CAREFUL TO ENSURE THAT THEY ARE KEPT ON UNTIL THE PERMANENT CROWNS ARE DELIVERD. I REALIZE THE FINAL OPPORTUNITY TO MAKE CHANGES TO MY NEW CROWNS, BRIDGES OR CAPS (INCLUDING SHAPE, FIT, SIZE, AND COLOR) WILL MADE BEFORE CEMENTATION. TEMPORARY CROWNS SHOULD ONLY BE WORN FOUR (4) WEEKS.
INITIALS _____

6. ENDODONTIC TREATMENT (ROOT CANAL): I UNDERSTAND THAT MANY FACTORS CONTRIBUTE TO THE SUCCESS OF NERVE TREATMENT AND CAN NOT BE DETERMINED IN ADVANCE. SOME OF THESE FACTORS ARE: MY RESISTANCE TO INFECTION, THE LOCATION AND SHAPE OF THE CANALS IN THE TOOTH, ADJACENT NERVE INVOLVEMENT, AMOUNT OF INFECTION, ETC. I FURTHER REALIZE THAT THERE IS NO GUARANTEE THAT A ROOT CANAL TREATMENT WILL SAVE THE TOOTH, THAT COMPLICATIONS CAN OCCUR FROM THE TREATMENT, AND THAT OCCASIONALLY METAL OBJECTS ARE CEMENTED IN THE TOOTH OR EXTENDED THROUGH THE ROOT CANAL WHICH DOES NOT NECESSARILY AFFECT THE SUCCESS OF THE TREATMENT. I UNDERSTAND THAT OCCASIONALLY ADDITIONAL SURGICAL PROCEDURES MAY BE NECESSARY FOLLOWING A ROOT CANAL TREATMENT SUCH AS AN APICOECTOMY.
INITIALS_____

7. MINORS/ CHILDREN: I AGREE TO BE PHYSICALLY PRESENT ON THE PREMISES THROUGHOUT MY CHILD'S VISIT, SHOULD THE DOCTOR NEED TO ASK QUESTIONS ABOUT MY CHILD'S TREATMENT OR TO GET MY PERMISSION TO MAKE CHANGES IN MY CHILD'S TREATMENT.
INITIALS_____

8. PERIODONTAL/ AMT THERAPY: I HAVE BEEN INFORMED THAT THE PURPOSE OF PERIODONTAL THERAPY IS TO TREAT MY PERIODONTALLY DISEASED GUM TISSUE. DUE TO INDIVIDUAL PATHOLOGY AND BONE LOSS, THERE EXISTS A SMALL RISK OF FAILURE, RELAPSE, SELECTIVE RE-TREATMENT, OR WORSENING OF MY PRESENT CONDITION DESPITE THAT BEST PERIODONTAL CARE. I AM AWARE OF POSIBLE COMPLICATIONS AND POST-TREATMENT RISKS WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO: SWELLING, DISCOMFORT OR INFECTION IN THE MOUTH, RESTRICTED MOUTH OPENING, ESTETIC CHANGES SUCH AS GUM RECESSION THAT MAKES THE TOOTH APPEAR LONGER AND MAY EXPOSE CROWN MARGINS, SENSITIVITY TO HOT OR COLD FOR DAYS, WEEKS OR OCCASIONALLY MONTHS. I UNDERSTAND THAT LONG- TERM CONTINUED PERFORMANCE OF EXCELLENT ORAL HYGIENE AND PLAQUE REMOVAL AND MY AVAILABILITY FOR REGULAR RECARE VISITS.
INITIALS_____

9. PREMEDICATIONS/ SEDATION: I UNDERSTAND THAT SEDATION OR PREMEDICATIONS INVOLVES RISKS AND HAZARDS INCLUDING DROWSINESS , DISORIENTATION, IMPAIRED MOTOR SKILLS, IMPAIRED JUDGEMENT, MENTAL CLOUDINESS OR CONFUSION, NAUSEA, AND ALLERGIC OR DRUG REACTION. HOWEVER, I REQUEST THE USE OF SEDATION FOR RELIEF OF AND PROTECTION FROM PAIN DURING MY VISIT. IF THE PATIENT IS A CHILD, I AGREE TO MONITOR THE CHILD FOR 6-8 HOURS FOLLOWING THE OPERATIVE VISTIT AND WILL NOT SUBJECT THE CHILD TO ANY SITUATION WHERE IMPAIRED MOTOR SKILLS OR DROWSINESS COULD CAUSE POSSIBLE DANGER TO THE CHILD.
INITIALS_____

I UNDERSTAND THAT MEDICATIONS, DRUGS, ANESTHETICS, AND PRESCRIPTIONS MAY CAUSE DROWSINESS AND LACK OF COORDINATION, WHICH CAN BE INCREASED BY THE USE OF ALCOHOL OR OTHER DRUGS. I HAVE BEEN ADVISED NOT TO OPERATE ANY VEHICLE, AUTOMOBILE, HAZARDOUS DEVICES OR MACHINERY OR WORK WHILE TAKING SUCH MEDICATION, AND/ OR DRUGS, OR UNTIL FULLY RECOVERED FROM THE EFFECTS OF SAME. I AGREE NOT TO DRIVE MYSELF HOME AFTER SURGERY AND WILL HAVE A RESPONSIBLE ADULT DRIVE ME OR ACCOMPANY ME HOME AFTER MY DISCHARGE FROM THE OFFICE IF I AM SEDATED.
INITIALS_____

I HAVE NOT TAKEN ANY SUBSTANCES OF ABUSE (DRUGS, LEGAL OR ILLEGAL: ALCOHOL; NARCOTICS; AMPHETAMINES; DIET PILLS; ETC.) THAT ARE UNKNOWN TO THE DOCTOR. I ALSO AM NOT TAKING ANY MEDICATIONS FROM MY PHYSICIAN THAT HAVE NOT BEEN DISCLOSED TO THE DOCTOR. FURTHERMORE, I DO NOT HAVE ANY PHYSICAL OR PSYCHOLOGICAL CONDITIONS THAT I HAVE NOT DISCLOSED TO THE DOCTOR.
INITIALS_____

I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE UNDER HIS/HER CARE, REALIZING THAT LACK OF COOPERATION COULD RESULT IN LESS THAN OPTIMAL RESULTS. I REALIZE THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THAT REPUTABLE PRACTIONERS CAN NOT PROPERLY GUARANTEE RESULTS. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE BY ANYONE REGARDING THE DENTAL TREATMENT THAT I HAVE REQUESTED AND AUTHORIZED. I UNDERSTAND THAT EACH DENTIST IS AN IDIVIDUAL PRACTIONER AND IS INDIVIDUALLY RESPONSIBLE FOR THE DENTAL CARE RENDERED TO ME.
INITIALS_____

_____ _____

DATE **SIGNATURE OF PATIENT/RESPONSIBLE PARTY**

_____ _____

DR. SIGNATURE **SIGNATURE OF WITNESS**