The Geller Dental Group P.C.

COMPREHENSIVE CARE FOR THE ENTIRE FAMILY

TREATMENT PLAN CONSENT

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As a result of our clinical and radiographic examination, along with a full mouth analysis, the following enclosed treatment options are recommended to correct the problems that exist with your teeth and oral tissues. All reasonable options, along with their advantages and disadvantages will be discussed. It is your decision as to which treatment option you wish to pursue. In addition to the recommended treatment options, there is an estimate of the fees involved. If a treatment option is not chosen in its entirety, the fees will be adjusted accordingly. The estimated fees are valid for 120 days from the date of the estimate and any treatment which begins after 120 days may be subject to increased fees.

The cost of treatment is only an estimate. If your treatment proceeds without any alteration, the final cost will be close to the estimated cost. However, it is important to keep in mind that during the course of treatment, additional unforeseen treatment may be required to properly treat your dental condition. In this event, the cost of the additional treatment will be added to the overall cost of your treatment. If the additional treatment involves the placement of small restorations, the additional cost will be moderate. In some circumstances however, the cost of additional treatment may be substantial if the treatment plan undergoes significant change. These changes will only occur with your consent.

If you have dental insurance, we will submit a predetermination form to your insurance company to receive a confirmation of your dental coverage for the proposed treatment. At the completion of your treatment, we will submit an insurance form to claim your dental reimbursement from your insurance company. Fees related to your insurance company's reimbursement are only an estimate and cannot be guaranteed. Any monies received from your insurance will be deducted from your overall balance as they are received. It is important that you understand that you are responsible for full payment of our fee.

The practice of dentistry is not an exact science and therefore we cannot ethically guarantee results. It is important for you to understand that treatment may or may not be successful and that with dental treatment, there is the risk of possible complications. We are unable to predict whether a specific treatment plan on an individual will be successful or whether complications will arise. Due to the wide variety of use and abuse of dental restorations by patients, we are unable to determine how long a restoration will survive in an individual and should the restoration or prosthesis require repair or replacement, there will be a fee charged.

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives, and that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand. My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.

2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.

3. I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there will be additional fees related to the additional time and treatment. Normal and usual treatment consists of 1 or 2 try–ins of the restoration and up to 5 post–insertion adjustments.

4. I understand that my dentist has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.

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5. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.

6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.

7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

8. My dentist has explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces, and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

9. I agree to follow the home care instructions provided to me. I agree to report to The Geller Dental Group, P.C. for regular examinations as indicated and I understand that this office will monitor my progress.

10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

11. I consent to photography, study models and X–rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

12. I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove the bacterial plaque off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail. I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

Patient Name: ______________________ Signature: ______________________ Date: __________
Please Print

Doctor Name: ______________________ Signature: ______________________ Date: __________
Please Print