remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by Tanada-Lee Family Dental Care. The advantages and disadvantages of alternate materials have been explained to me. **(initials)_____**

**7.REMOVAL OF TEETH:**

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

- Possible bone fracture which require wiring or surgical treatment.
- Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
- Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
- Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage( possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of die lip,chin,gums,cheek,teeth,and/or tongue on the operated side: this may persist for several weeks, months, or, in remote instances, permanently.

**(initials)_____**

**8.Pedodontics (Child Dentistry):**

I understand that the following procedures are routinely used at Tanada- Lee Family Dental Care, as well as being accepted procedures in the dental profession.

- Positive Reinforcement-Rewarding the child who portrays desirable behavior, by the use of compliments, praise, a pat or hug, and/or token objects or toys.
- **Voice Control-** The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
- **Physical Restraint-** Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by the use of the dentist's or assistant's hand or arm, pr by use of a special device (referred to as a "papoose boar').
- **Nitrous Oxide And/Or Oral Sedation-** Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day. **(initials)_____**

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT TANADA-LEE FAMILY DENTAL CARE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY

Print Patient's Name_____SIGNATURE:_____

Relationship:_____Date:_____

Doctor: _____ Witness_____