

HAMID GIAHI DDS.

General Dentistry Informed Consent

EXAMINATION

I understand that my dentist needs to make an oral examination on me and I hereby permit him to perform the exam.

(1) Initials: _____

X-RAYS

I understand that my dentist may need to take one of several x-rays, and I hereby give permission for these x-rays to be taken. I understand that I must inform the dentist if I am pregnant or suspect that I may be pregnant.

(2) Initials: _____

PHOTOGRAPHS

I understand that Dr. Giahi and his associates/staff need to take one or more photograph/s of my teeth and other parts of my mouth and I hereby permit them to take those photograph's.

(3) Initials: _____

CLEANING

I understand that I need cleaning of my teeth and gums in order to maintain their health, and hereby I give permission to Dr. Giahi & his Auxiliaries to perform cleaning and polishing of my teeth. I understand that after cleaning and polishing, I might develop some sensitivity and minor scratches on my gums.

(4) Initials: _____

PROCEDURES TO BE PERFORMED

I understand that I am having the following procedure(s) performed: Fillings (), Bridges (), Crowns (), X-Rays (), Extractions (), Impacted Teeth Removal (), Root Canals (), Dentures (), Bleaching (), Other: _____

(5) Initials: _____

DRUGS & MEDICATIONS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and anaphylactic shock.

(6) Initials: _____

REMOVAL OF TEETH

Alternative to removal have been explained to me (RCT, Crowns, Periodontal Surgery, etc.) and I authorize the Dentist to remove the following _____ and any others necessary for reason in paragraph #3. I understand removing teeth does not always remove all the infection present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infections in pockets, and loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I might need to be referred to a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(7) Initials: _____

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 easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity for any change in my new crown; bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

(8) Initials: _____

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally, an additional surgical procedure may be necessary following root canal treatment (apicoectomy).

(9) Initials: _____

PERIODONTAL LOSS (TISSUE & BONE)

I understand that if I have a serious condition, causing gum and bone inflammation or loss, it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have further adverse effects on my periodontal condition.

(10) Initials: _____

FILLINGS

I understand that care must be exercised in chewing on the filling, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is common after the effect of a newly placed filling. I understand that I have an option to choose between a silver filling (amalgam) and a white filling (tooth colored or composite) and if the insurance doesn't cover the white filling, I am willing to pay the difference.

(11) Initials: _____

STATE OF CALIFORNIA WARNING

Amalgam fillings contain a chemical element known to the State of California to cause birth defects or other reproductive harm.

ADVERTENCIA

Rellenos de amalgam contienen un elemento que el estado de California sabe causa defectos de parto y otros danos reproductivos

DENTURES

I understand the wearing of dentures is difficult, and sore spots, altered speech, and difficulties in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjustment and several relinings. A permanent relinings 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 denture. I understand a remake is required due to my delays of more than 30 days, and there will be additional charges.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or Dr. Giahi & Associates is responsible for my dental treatment.

(12) Initials: _____

I hereby authorize any of the doctors or dental auxiliaries of Dr. Giahi to proceed with and perform the dental restorations & treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable 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 dental fees. I agree that my insurance company to pay my dentist directly and issue checks under his name for claims he sends. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, that is, whether any dental service rendered was allegedly unnecessary, unauthorized, or was improperly, negligently, or incompetently performed, said dispute will be submitted to peer review by the local component of the American Dental Association. The decision of the peer review shall be binding on both parties.

I am of legal age and legally competent to make this assignment.

Patient/Guardian Printed Name:

Chart No: _____

Signature of Patient/Guardian: _____

Date: _____

Signature of Dentist: _____

Date: _____