CRANSTON COSMETIC DENTISTRY

Informed Consent

PATIENT INFORMATION			
First Name		Last Name	
Birth Date		Phone #	

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. You will be asked to sign additional consent forms for other treatments according to treatment plan. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

During your course of treatment, the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS**
  Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. In the State of Rhode Island, a dental hygienist ***cannot*** diagnosis a patient.
- **DENTAL PROPHYLAXIS (CLEANING)**
  A routine dental prophylaxis involves the removal of plaque and calculus *above the gum line* and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

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. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Allergies/Medication

I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

COVID-19

You are receiving dental care during the pandemic events of COVID-19 National Emergency. Please be advised that there may be increased risk of exposure from doctors, staff, other patients, and the treatment facility. We are taking precautions to limit the spread of this disease, but there is still a possibility of transmission.

I understand that COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits on virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I do hereby acknowledge the health risks of the COVID-19 virus during this National Emergency and I willfully request and authorize the doctors and staff at Cranston Cosmetic Dentistry to perform any necessary dental services.

We hold ourselves to the highest standards of cleanliness because we value your health and safety.

Consent

I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

FORM COMPLETION			
Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR			
Form signed by		Relationship to Patient	