ALTER BIO DENTAL orDr. Sergei Agafontsev D.M.D.
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TREATMENT PLAN CONSENT FORM

Patient Name _______________________________ Date _______________________________

1. DIAGNOSTIC AND_PREVENTIVE I understand that I am having the following work done:
Xrays______Cleaning______ Scaling_______ Root P. _______ (Initials _______)

2. DRUGS, MEDICATIONS AND LOCAL ANESTHETIC I understand that antibiotics, analgesics and other medications can cause allergic reactions, and/or anaphylactic shock. I understand there are risks of local anesthesia that may affect my body. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history. (Initials______)

3. RESTORATIONS (FILLINGS) I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that if my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns. (Initials ________)

4. CROWNS AND BRIDGES I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I 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 to make changes in my new crown or bridge will be before cementation. (Initials_____)

5. DENTURES, COMPLETE OR PARTIAL I realize that full or partial dentures are artificial, made of plastic, metal and/or porcelain. The problems of wearing dentures have been explained to me. Looseness, soreness, and possible breakage may occur. I realize the I can request changes to my new dentures at the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the denture fee. (Initials______)

6. 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 metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

7. CHANGES IN TREATMENT PLAN I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care and understand that the fee proposed is subject to change, depending upon those unforeseen or undiagnosed conditions that may only become apparent once treatment has begun. (Initials ________)

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a mutual understanding between provider and patient. I understand that dentistry is not an exact science and that, therefore, practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment. I understand that the office policy requires payment in full at the time of treatment. If accounts are not paid within 90 days, I will be responsible for interest charges and other fees that may incur during collection. I authorize staff to perform any services needed during diagnostic and treatment. I authorize release of information to be submitted electronically to my insurance company. I authorize direct payment to the dental office for benefits from claims submitted.

Signature of patient or legal guardian ____