PUJA GABA, D.D.S. Patient: _____

1. **WORK TO BE DONE**
I understand that I am having the following work done: Fillings [ ], Crowns [ ], Bridges[ ],Extractions [ ],Impacted teeth removed [ ], Root Canals [ ],Dentures [ ],X-rays[ ], Periodontal Treatment[ ],other (Initials_____)

2. **DRUGS AND MEDICATION**
I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. (Initials_____)

3. **PARESTHESIA**
I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia with any procedure. (Initials_____)

4. **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. For example, I may need a root canal therapy following routine restorative procedures. The dentist will explain all changes. (Initials_____)

5. **REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons as explained. I understand removing the teeth may not always remove all the infections 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, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

6. **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 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 crown; bridge or cap (including shape, fit, size and color) will be before the cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation. (Initials_____)

7. **ENDODONTIC TREATMENT**
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 may extend beyond the tooth root, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it. (Initials_____)

8. **PERIODONTAL TREATMENT**
I understand that I have a condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including gum surgery, locally administered antibiotics, replacements and/or extractions. (Initials_____)

9. **FILLINGS**
I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity is common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done. (Initials_____)

10. **DENTURES**
Sore spots, altered speech and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (Initials_____) I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. (Initials_____)

Signature of Patient _____ Date _____

Signature of Doctor _____ Witness _____

Treatment policies

Payment for Services: Payment is the responsibility of the patient. If the patient is a minor, the guardian present at the initial appointment is responsible for payment of any charges. Failure to keep this account current may result in the office being unable to provide additional dental services except for dental emergencies.

Dental Insurance: We will submit your insurance as a courtesy to you on your behalf to your insurance company. Your dental insurance may pay less then the actual bill for services. Communication with dental insurance companies has become difficult lately. You may be called upon to rectify problems with your insurance. You are responsible for any unpaid portion.

Cancelled and Broken Appointment: The scheduling of an appointment involves the reservation of time set aside specifically for you. A minimum of 24 hours notice is required to reschedule or cancel an appointment. Please note that if you do not keep your appointment or fail to cancel within 24 hours period you will be charged 30 percent of the full fee for the appointment.

Returned Checks: There is a $25 fee for any returned check. Future appointments will not be scheduled until payment for the returned check and the $25 fee is made in full by cash or cashier's check.

After Hours Emergency Procedures: If you need emergency dental care after hours, please call the office phone number. Follow the instructions. If it is not a dental emergency leave a message after the tone.

Periodontal Treatment: Patients with active gum disease (periodontal disease) will undergo gum treatment (scaling and root planning) to help correct this condition. This is the instrumentation of the crown and root surface to remove plaque and calculus for these surfaces. It is therapeutic and not prophylactic in nature. This may be a definitive treatment in some stages of periodontal disease. It can also be post or pre-surgical procedure on others.

Periodontal Maintenance: This is for patients who have previously been treated for periodontal disease. It starts after completion of active periodontal therapy and continues at varying intervals, determined by the clinical diagnosis of the dentist, for the life of the dentition. It includes removal of the supra and sub gingival plaque and calculus, site specific scaling and root planing where indicated, and/or polishing the teeth. When new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

Should you have any questions about these policies, or any other aspect of your treatment, please discuss it with our office manager.

I have read and understand the policies described above.

Signature: _____ Date: _____

Print Name: _____