California Wave Dental Center, Inc.

166 North Moorpark Rd Suite 202 Thousand Oaks CA 91360
TEL: 805.497.7505
FAX: 805.497.3326

GENERAL CONSENT FORM

PATIENT NAME: ______________________________

Please read and initial each categories and sign at the bottom

1. **EXAM, X-RAY, SEALANTS, PROPHYLAXIS**: I understand all the advantages/ disadvantages of x-ray, sealant, and prophylaxis (cleaning) treatment I will be receiving. I understand that I will be exposed to a limited amount of radiation when receiving x-rays. I understand that sealants are not a guarantee of cavity prevention (Initial:____________)
2. **MEDICAL HISTORY INFORMATION**: I understand that it is important to give all information about my medical history to the dentist and inform any medications that you are taking or you took in history, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or with other medications. I understand that I will provide with a list of any allergies. (Initial:____________)
3. **DRUGS AND MEDICATIONS**: I understand that antibotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction). (Initial:____________)
4. **CHANGE IN TREATMENT PLAN**: I understand that during treatment if 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. (Initial:____________)
5. **HYGIENE:** I understand that the long term of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. (Initial:____________)

PERIO:

6. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that I have a serious condition causing gum and bone inflammation and/or loss and that it can be lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. (Initial:____________)

RESTORATIVE:

7. **RESTORATIONS**: I understand the advantages/disadvantages of the filling materials. I understand that care must be exercised in chewing on fillings and crowns until directed by the doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay or the condition of remaining tooth structure. I understand that sensitivity may occur after a newly placed filling or crown. I also have been informed that in some cases, root canal treatment may be required following restoration. I realize that a large filling may not be a good long term solution and may lead to tooth breakage that will require further treatment. (Initial:____________)
8. **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 to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. (Initial:____________)

ENDO:

9. ENDODONTIC TREATMENT (ROOT CANAL 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 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) (Initial:____________)

EXTRACTION:

10. **REMOVAL OF TEETH:** alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth and any others necessary for reasons. I understand removing teeth does not always remove all the infection. If 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 infection, dry sockets, loss of feeling in my teeth, lips, tongue and surrounding tissues (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization. If complications arise during or following treatment, the cost of which is my responsibility. (Initial:____________)

DENTURES:

11. DENTURES, COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be 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 initial denture fee. (Initial:____________)

12. DENTURE: I understand the wearing dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline may be recommended later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery for the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. It a remake is required due to my delays of more than 30 days, there will be additional charges.

(Initial:____________)

I understand that that no guarantee or assurance has been given that the proposed treatment will be curative and successful to my complete satisfaction. I agree to care realizing that any lack of the same could result in less than optimum results.
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 have received a copy of the Dental Materials Fact Sheet as required by law

____
PATIENT (PRINT)

______________________________ ______________________________
PATIENT (SIGNATURE) DATE

California Wave Dental
166 N. Moorpark Rd. Thousand Oaks, CA. 91360 Suite #202
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Broken Appointment Policy

Definition:

A scheduled appointment is considered a broken appointment when the patient:

- Cancels the appointment with less than 24 BUSINESS hours
- Fails to keep the appointment time
- Is more than 20 min. late

Broken Appointment Charge

As a patient, we hope you can and realize the time the dentist sets aside for a patient is very valuable. Broken appointment's make it difficult for our office to maintain a schedule that is efficient for our staff and convenient for our patient's. For this reason, patient's will be charged for broken appointment's. The broken appointment charge is $50.00 for each 30 minute block of time. This charge is NOT a penalty, but an attempt to maintain fair compensation for the time needed for care and cost of time.

Patient has discussed the following appointment rules with the doctor(s) and office staff, and assured that the patient understands the full terms of the appointment conditions. A verbal translation of this form was given in patient's language if the patient was unable to read or write in English.

______________________________ Patient's Signature

_______________ Date

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DENTAL MATERIALS FACT SHEET

PATIENT NAME: ______________________________

I have received a copy of the Dental Materials Fact Sheet as required by law, and I have had a chance to discuss and ask any questions regarding the dental materials with the dentist.

____
PATIENT (PRINT)

______________________________ ______________________________
PATIENT (SIGNATURE) DATE

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,______________________________ [full name], have received a copy of the __________________________ [name of practice] Notice of Privacy Practices.

Print Name____

Signature ____

Date ____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name ____

Relationship to Patient ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)