

INFORMED CONSENT
Salem Dental Studio
Steven N. Lind DMD PC
(503) 566-7000
Fax: (503) 363-8886

Patient Name: _____ Date: _____

You have the right to be informed about your condition[s] and the recommended treatment plan so that you may make an informed decision about whether or not to undergo procedures after knowing the risks involved. This disclosure is not meant to alarm you, but rather an effort to properly inform you so that you may withhold or give your consent. I hereby authorize Dr. Steven N. Lind and his clinical staff to perform the following procedures, which have been explained to me. I understand these procedures are either elective or necessary to treat the conditions, which have also been explained to me. I understand that the nature of the procedures to include: All procedures recommended on Treatment Plan.

I understand that alternative treatments including, no treatment at all, are choices that I have and the risks of those choices have been explained to me. I understand that these alternative treatments may include:

Implants Bridges Crowns Dentures/Partials Inlays/Onlays Extractions
Amalgam/Composite Root Canal Treatment No Treatment other Tx: _____

I have chosen to do: [please initial] _____ Recommended Treatment _____ Alternative Treatment _____

I understand that during the course of treatment, post-operative care, anesthesia and other procedures, unforeseen conditions may necessitate additional treatment than those set forth above. Therefore, I authorize the performance of such other treatment as may be necessary in the exercise of my professional judgment. I have also been made aware that certain medications, drugs, anesthetics and prescriptions, which I may have been given, can cause drowsiness, coordination difficulty and lack of awareness. I have been instructed not to drive or operate machinery at work for at least 24 hours until fully recovered from the said effects.

TREATMENT RISKS: I UNDERSTAND THAT ANY TIME A RESTORATION IS PERFORMED THERE IS A POSSIBILITY OF TRAUMA TO THE NERVE OF THE TOOTH, WHICH COULD RESULT IN VARYING DEGREES OF SENSITIVITY AND COMPLICATIONS INCLUDING BUT NOT LIMITED TO THE FOLLOWING: **cold sensitivity, hot sensitivity, biting sensitivity, abscess, pulp necrosis.**

Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient Signature _____ Date _____

Staff Signature _____ Date _____