GENERAL INFORMED CONSENT

1. EXAMINATION AND X-RAYS:
   I understand that the initial/periodic visit will require radiographs in order to complete the examination, diagnosis, and treatment plan. I hereby, give my consent to take x-rays. (Initials______)

2. DRUGS , MEDICATION, AND SEDATION:
   I have been informed and 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).
   (Initials______)

3. 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, with the most common being root canal therapy following routine restorative procedures. (Initials______)

4. TEMPRO-MANDIBULAR JOINT DYSFUNCTION (TMD)
   I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein in the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials______)

5. DENTAL PROPHYLAXIS (CLEANING):
   I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tarter & stain from the tooth in the absence of periodontal (gum) disease. This treatment prevents gingivitis and gum disease.
   (Initials______)

6. DEBRIDEMENT (CLEANING):
   I understand that this type of cleaning is preventative in nature and intended for clients with gingivitis (inflamed & bleeding gums) and is for the removal of heavy build up of tarter and stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gum disease.
   (Initials______)

7. DENTAL INSURANCE BENEFITS:
   I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Teran's recommendations for optimal dental treatment. I understand that ITC Dental is confirming my dental benefits and billing my insurance for treatment as a courtesy, and declined claims for payment will become patient responsibility.
   (Initials______)

Patient Signature____Date ____

Doctor Signature ____ Date____