

# INFORMED CONSENT

## 1. WORK TO BE DONE

I understand that the following treatments may be performed on me as part of my dental treatments: Fillings, Bridges, Crowns, Extractions, Impacted Teeth Removal, Root canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.

## 2. FILLINGS

Fillings are procedures in which the dentist removes decayed tooth structure of a faulty restoration and replaces it with composite or silver Amalgam fillings. I understand that these procedures can cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the time, these sensitivities are temporary and they will go away within one (1) or two (2) weeks. However, there are times that due to the depth of the filling in the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for root canal therapy and might possibly require a post and crown to be fully restored. I understand that the dentist can not guarantee that the teeth receiving fillings will not need to receive the above-mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling procedure does not correct the problem.

## 3. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting and/or anaphylactic shock (severe allergic reaction).

## 4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

## 5. 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 teeth outlined in the treatment plan and any others necessary. 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 risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surround tissue (Paresthesia) that can last for an indefinite period of time (day 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.

## 6. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness.

## 7. 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, and that if I don't have the permanent crown(s) placed permanent serious damage or loss of the tooth/teeth involved may ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

## 8. 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 been explained to me including looseness, soreness, and possible

breakage, and relining due to tissue and bone change. I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointed 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.

#### **9. 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, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

#### **10. PERIODONTAL LOSS (TISSUE AND BONE)**

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

#### **11. a. ARBITRATION**

Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and Jeffrey Phen D.D.S. concerning the quality of patient services provided to the patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

**I.** Patient understands and agrees that any and all disputes between patient and Jeffrey Phen D.D.S. or its providers shall be resolved by submission to binding arbitration conducted by the American Arbitration Association (AAA). Such disputes or controversies include, but are not limited to, complaints concerning the quality, necessity or outcome of services provided pursuant to this Informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this Informed Consent Form. Patient further recognizes that by consenting to binding arbitration, patient is giving up the right to have such disputes decided in a court of law and/or before a jury.

**II.** A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

#### **b. INITIATION OF ARBITRATION**

Arbitration can be initiated by filing a demand for arbitration with the AAA, location at 225 Bush Street, 18th floor, San Francisco, CA. 94104-4207, Telephone number (415)981-3901. A demand form may be obtained from the AAA.

#### **c. COSTS**

In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administration fees connected therewith. If the patient prevails in arbitration, the patient may be entitled to reimbursement of costs including reasonable attorney's fees incurred in connection with the arbitration proceedings. Any such award of cost shall be made at the discretion of the arbitrator.

#### **d. LOCATION**

Arbitration proceedings shall occur in the county where the patient's treatment was performed, unless all parties to the arbitration otherwise mutually agree in writing.

**e. FORMS OF DECISION**

The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The arbitrator’s award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

I hereby request and authorize the dentist, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney’s fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Paresthesia), fractured jaw, Temporo mandibular joint (TMJ) Complications, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME. **NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 11 OF THIS CONTRACT.**

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_ Doctor: \_\_\_\_\_  
(Patient or Legal Representative)

Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

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Please Print Name

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Signature

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Date

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## 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)

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# Dental Office Photo & Video Consent Form

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, the undersigned, authorize and grant Jeffrey Phen, DDS A Dental Corporation ("DENTAL OFFICE") a license to take, use and reproduce photographs and/or videos of me and especially of my face, teeth, and mouth for the following purposes:

- 1. Dental Records:** To document and maintain a visual record of my dental condition, including images of my teeth, mouth, and face, for diagnostic, treatment planning, and medical record-keeping purposes.
- 2. Treatment Documentation:** To assist in providing and documenting dental treatment, including before-and-after images that may be used for treatment comparison and evaluation.
- 3. Educational and Training Materials:** To create educational materials for dental professionals, staff training, and patient education, which may include photographs or videos demonstrating dental procedures or case studies. These materials may be used within the practice, during professional presentations, or online.
- 4. Marketing and Promotional Materials:** To use select photographs and videos for marketing and promotional purposes, which may include the dental office's website, social media profiles, brochures, newsletters, and other marketing materials.

## Revocation of Consent:

I have the right to revoke this consent at any time, by providing 60 days written notice. Dental Office shall have the right to continue to use the Marketing materials during the 60 days notice period and shall further have the right to exhaust its supply of products containing any portion of the Marketing Materials ordered or received prior to Dental Office's receipt of the written notice.

## Expiration of Consent:

This consent for photograph and video use will remain in effect unless revoked by the patient or until the termination of the doctor-patient relationship.

## Patient Signature:

By signing below, I acknowledge that I have read and understood the above terms and voluntarily consent to the use of photographs and videos as described without royalty or compensation of any kind, in unlimited quantities and for an unlimited period of time. I therefore release Dental Office and any of its associated or affiliated companies, their owners, directors, officers, agents, employees and appointed advertising agencies from all claims of any kind arising out of the use of the Marketing Materials as described herein.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_