-PATI T CONSENT TO TREATMENT (this n is double-sided)

PATIENT NAME _____ CHART NO._____

In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate.

1. 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 **Laguna Village Dental** 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 **Laguna Village Dental** or its providers shall be resolved b 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.

II. 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. 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, located 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 administrative 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 patients treatment was performed, unless all parties to the arbitration otherwise agree in writing.

e. FORM 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.

Initials: _____

2. 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, Impacte Teeth Removal, Root Canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.

Initials: _____

3. 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 that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary

Initials: _____

4. 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 (sever allergic reaction).

Initials: _____

5. FILLINGS

Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with Composite or Silver Amalgam fillings. I understand that these procedures could 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 a 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 restor the teeth, if the initial filling procedure does not correct the problem. I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines.

Initials: _____

6. REMOVAL OF TEETH

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if t condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following: **A.** Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring, prescriptions or additional treatment, i.e. surgery). **B.** Injury to adjacent teeth, caps, or fillings (requiring the re-cementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to othe tissues not within the described surgical area. **C.** Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibula joint (jaw joint) difficulty (possibly requiring physical therapy or surgery). **D.** Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications. **E.** Possible bone fracture which may require wiring or surgical treatment. **F.** Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. **G.** Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, check, teeth, and/or tongue on the operated side; this may persist for several week months, or in remote instances, permanently.

Initials: _____

7. PEDODONTICS (CHILD DENTISTRY)

I understand that the following procedures are routinely used at this dental office, as well as being accepted procedures in the dental profession: **A. Positive reinforcement** – rewarding the child who portrays desirable behavior, by use of compliments, praise, and/or toys. **B. Voice Control** – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice. **C. Physical restraint** – Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistants hand or arm or by use a special device (referred to as a "papoose board"), such

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INFORMED CONSENT – (continued from front - this form is double-sided)

D. Nitrous oxide and/or oral sedation – Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administe through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the pare guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation appointment, and observe their behavior throughout the day.
I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertentl their lip causing injury to occur. I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away a sufficient period of time. I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

Initials: _____

8. 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.

Initials: _____

9. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during t preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crow and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment. I further understand that I may be wearing temporary crowns, which may come o 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.

Initials: _____

10. 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 b explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change. Follow-up appointments are a integral part of maintenance and success of a prosthetic appliance. I further understand that surgical intervention (i.e. tori[bone] removal, bone contouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, never be able to wear dentures to my satisfaction.

Initials: _____

11. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur from treatment, and that occasionall metal objects are cemented in the tooth or extend through the root which does not necessarily effect 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 prescribe treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crow (cap) over the tooth. I understand that treatment risks can include, but are not limited to:
A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor. **B.** P treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer. **C.** Infection d. Restricted jaw opening **E.** Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in th treated root canal or bone as part of the filling material; or it may require surgery for removal. **F.** Perforation of the root canal with instruments, may require additional surgical treatment or result in premature tooth loss or extraction. **G.** Risk of temporary or permanent numbness in treatm area. If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

Initials: _____

12. PERIODONTAL TREATMENT (TISSUE AND BONE)/ PROPHY

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing flossing) and maintaining regular recall visits. I understand that I have a serious condition, causing gum and bone inflammation or loss and that lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may requ extraction.

Initials: _____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appea function and the health of my mouth, teeth), bone and tissues, as explained above. The effect and nature of the proceeding to be performed, an risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist a Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diag treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation. I know that the practice of Dentistry 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, scarri 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, (Parasthesia), fractured jaw, Temporomandibular Joint (TMJ) Complications, which could cause localized 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, INCLUDING THE OPPOSITE SIDE OF THIS DOCUMENT, AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DO NOT UNDERSTAND HAS BEEN EXPLAINED TO ME. I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMINATION BASED ON RACE, RELIGION. COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MEI DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS. NOTICE: BY SIGNING TH CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRA AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature: _____ _____ **Relationship:** _____ **Date:** _____
Patient or Le epresentative