MURRAY L. RABALAIS., P.D., D.D.S.
PERIODONTICS

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires that we obtain your informed consent prior to beginning any treatment. What you are being asked to sign is a confirmation that we have discussed your diagnosis, the nature and purpose of the proposed dental treatment, the known risks associated with this proposed dental treatment, and the feasible treatment alternatives; that you have been given an opportunity to ask questions and that all your questions have been answered in a satisfactory manner; and that all the blanks in this form were filled in prior to your signing it. Please read this form carefully before signing it and ask about anything that you do not understand. We will be pleased to explain.

NATURE AND PURPOSE OF RECOMMENDED DENTAL TREATMENT

The following dental procedure has been recommended

_____ 1. Maxillary Frenectomy_____

A maxillary frenectomy is the removal of a high frenum attachment to help with orthodontic treatment. An alternative to this treatment is not performing the surgery which may result with poor or less than adequate orthodontic results.

_____ 2. Crown Lengthening_____

Crown lengthening is a procedure to increase the length of tooth which protrudes out of the bone. The purpose is to give the dentist an adequate amount of tooth upon which to place a suitable crown. Alternatives to the crown lengthening procedure would be to remove the tooth or not having the surgery. Leaving a short crown would result in a poor crown fit and a high probability of decay around the crown margin.

_____ 3. Fiberotomies_____

Fiberotomies are performed to help in orthodontic treatment to prevent some of the relapse that may occur. Alternatives to the fiberotomy procedure would be not having the surgery performed and increasing the length of time that the retainers would be worn and/or relapse of the orthodontic positioning of the teeth.

_____4. _____

RISKS ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT

I understand that dentistry is not an exact science and that complications do occur. I confirm that I have been given no guarantee or assurance by the dentist whose name appears below, or by anyone else, as to the results that may be obtained from treatment. The following risks known to be associated with this procedure and with the associated anesthetic have been explained to me. These complications although very uncommon, include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth, cracking or bruising of the corners of the mouth, and allergic reactions. I understand that the success of this treatment and the avoidance of treatment complications depends to a great extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following the instructions given to me concerning the wearing of prescribed dental appliances and other matters, and my keeping the appointments for treatment and follow-up that have been scheduled or recommended.

PUBLICATION OF RECORDS

I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes.

ACKNOWLEDGMENT

I acknowledge that I have read and that I understand the information on both pages of this consent form (or that it has been read to me), that I understand the information contained in it, including all of the technical terms, about which I have asked if unsure; that I have been given an adequate opportunity to ask whatever questions I had about the treatment; that all of my questions about the treatment have been answered in a satisfactory manner; and that I understand the diagnosis, the nature and purpose of the proposed dental treatment, its risks, and the alternatives to the proposed dental treatment.

I, hereby, authorize and direct Dr. Murray L. Rabalais, Jr., to perform this treatment on _____.

I further authorize and direct him to perform any other treatment related to this surgical procedure which in his judgment is advisable of my well-being, and to provide such additional services as he may deem appropriate including, but no limited to, the administration of any anesthetic agent. This consent form shall be valid until it is expressly revoked and the revocation is communicated to my dentist. I understand and agree that it is my responsibility to communicate any revocation of this consent to my dentist.

Date _____ Time_____

Signature of Patient_____

Signature of Relative (where required)_____

Signature of Witness_____

Signature of Doctor_____

PATIENTS WITH INSURANCE

I give my permission for Dr. Murray Rabalais or his designated staff member to release information concerning my case to my insurance company.

Signature of Patient_____ Date_____