Diamond Dental Spa
WOODLAND HILLS

Informed Consent for Services

Name: ______________________________

Initials _______ **DRUGS, MEDICATIONS, AND ANESTHETICS**
I understand that antibiotics, analgesics, and other medications can cause allergic reaction: redness, swelling, itching, pain, and/or anaphylactic shock. I understand that some medications may cause drowsiness and lack of coordination, which can increase with the use of alcohol or other drugs. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain with the potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Initials _______ **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. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials _______ **PERIODONTAL TREATMENT**
I understand that periodontal disease is a serious, progressive infection, causing gum inflammation and deterioration, bone loss, and can lead to loss of teeth. I understand that after treatment there can be tenderness, swelling, pain, sensitivity to temperature, and/or bleeding. Alternative treatment is available, including gum surgery, replacement teeth, and extractions. I understand that success depends in part on my efforts to brush, floss, and use mouthwash daily, follow maintenance schedule, and other recommendations.

Initials _______ **FILLINGS**
I understand that a more extensive filling that originally diagnosed may be required due to additional decay not seen on an x-ray. I understand that sensitivity to cold or pressure is common after newly placed fillings. I understand that the most common complications are sensitivity to temperature, fracture of the tooth, nerve damage, damage to the teeth, bite changes, and TMJ complications. I understand that all these complications are more likely the longer I wait to seek treatment.

Initials _______ **CROWNS, BRIDGES, AND VENEERS**
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. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days of the preparation date. Excessive delays may allow tooth movement or failure in the temporary, which may necessitate remakes. I understand there will be additional charges for remakes due to me delaying permanent cementation.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I hereby authorize Dr. Zin Kohan DDS and Diamond Dental Spa to proceed with the dental procedures/treatments as have been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for full payment of treatment fees.

Signature of Patient/Responsible Party
___________________________________Date ________________

Signature of Team member
____ Date
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