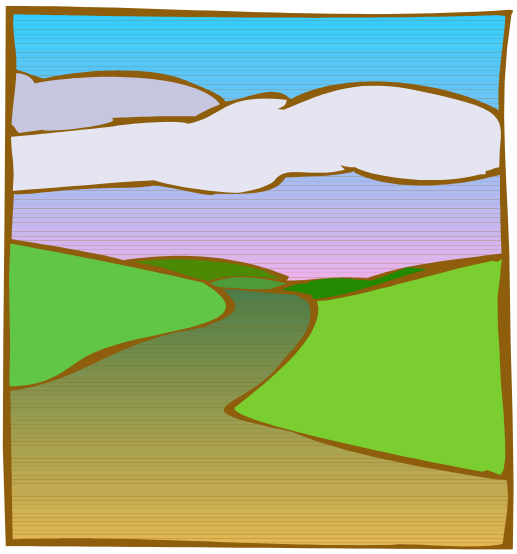
A Path to Dental Health

Great Patient



Treatment goals:

Stop pain
Stop decay
Reach your cosmetic goals
Improve chewing ability

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4/10/2015

Dear Great Patient,

Thank you for coming to our dental office today. We hope you were pleased with the care and services you received and that you will become part of our family of patients for a long time.

Thank you also for reviewing the information provided for you in this packet. It should answer most questions.

We enjoyed meeting you today and look forward to seeing you again. If you have further questions please do not hesitate to contact us.

Sincerely,

John Doctor, D.D.S.

Our philosophy of dental care

We believe good dental care is helped by good communication between the patient and the dental staff. An informed patient can make better decisions about choices for dental treatment. Our goal is to provide you clear information about your dental condition and the treatment choices available, and then to provide you the best appropriate dental care that we can.

We also want you to have pain-free dental care.

Preventive dentistry is an important part of our practice and begins with keeping the enamel of the teeth strong and resistant to decay. We focus on keeping the gums healthy and helping you resist diseases that threaten oral health. We use the very latest research information to assess your risk for decay and gum problems in order to design a program aimed at lessening the risk.

After preventive dentistry is addressed, we turn our attention to the following:

1. **Removal of hopeless teeth:** We keep in mind your desires to live free of pain, to be able to chew well, to have a pleasant smile, and to keep your expenditure for dental care controlled.

2. **Restoration of teeth:** We may consider using an alloy type of filling, a tooth-colored bonded filling, or crowns. We may recommend root canal therapy if an important tooth's nerve has been damaged from decay or trauma.

3. **Restoration of chewing ability:** We may suggest non-removable bridges, implants or removable appliances.

4. **Cosmetic care:** A variety of treatment is available, including whitening, bonding, veneers or crowns.

The real world of dental care can be quite fluid. We typically will work on all aspects of care simultaneously to ensure the best result for you.

Thank you for entrusting your oral care to us.

GREAT PATIENT
DENTAL CLINICAL EVALUATION REPORT
4/8/2015

Oral cancer examination: Negative.

Temporomandibular joint (TMJ): Some popping noted but no pain or limited function.

Head and neck examination: Head, eyes, nose, lips, face, trachea and thyroid area within normal limits.

Oral soft tissue (inside of cheeks, tongue, under the tongue, back of mouth): Median rhomboid glossitis

Saliva: Saliva has normal volume and consistency

Amount of plaque on your teeth: Moderate plaque accumulation

Amount of calculus (tartar) on your teeth: Mild calculus accumulation

Amount of stain on teeth: Mild stain noted

Amount of decay present: Moderate caries prevalence noted during clinical examination

Status of the gums and jawbone: Dental plaque induced gingivitis

Status of existing restorations: Good to fair

Brief evaluation of your smile: existing dental restorations detract from the smile, midline between the central incisors is not centered, missing teeth are affecting the smile.

Prosthetic analysis (dentures/partials/implants/bridges): No prosthetics

X-ray evaluation: Radiolucent lesion noted on radiograph, Caries noted on radiograph, Bony lesion noted on radiograph

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GREAT PATIENT

DENTAL CARE RECOMMENDATIONS

4/10/2015

This information will to help you understand the recommended treatment. Before beginning treatment, we want to be certain that we have provided you with enough information so that you are well informed. These recommendations are based on the visual examination(s) I have performed, X-rays, models, photos and other diagnostic tests accumulated and on my knowledge of your medical and dental history. I have also taken into consideration information you have given me about particular needs.

I recommend the following treatment(s) for you:

First care
Antibiotic medication, Temporary restoration, Medication for pain

Initiating care
Diagnostic study models (from impressions)

Preventive dental care
Dental cleaning and fluoride, Preventive dental products

Oral Surgery
Extraction of wisdom teeth

Endodontic care
Root canal, Top right first molar (# 3)

Periodontal care
Scale and root planing all four quadrants

Restorative care (such as fillings, crowns and veneers)
Composite restorations (tooth colored - bonding), crown restorations (cap - lab fabricated)

Special instructions

Remember to take antibiotics before your dental appointment for protection of your prosthetic joint.
Remember to eat breakfast before your dental appointments.
Check your blood sugar before your appointments.
Complete your consent forms before your next appointment.
Follow your preventive dental care instructions.
Relax! You are going to do great!

ESTIMATED TIME TO COMPLETE THE DENTAL CARE - Four to six weeks

PROGNOSIS: The prognosis or chance of success of the treatment is good

The chance of success of your dental care will be improved if you follow these suggestions:

Good oral home care, regular preventive dentistry recall appointments, strict compliance to keeping plaque off of your teeth, regular brushing and flossing, use of preventive dentistry products

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recommended, keep sugar intake to a minimum, professional attention to dental concerns you may observe or detect, radiographs as recommended, specialty care as recommended, physician consultation as necessary

ALTERNATIVE CARE

There are many ways to treat dental problems. I have provided my recommendations based on what I think best suits your needs. However, there are other ways that you can be treated, including:

No treatment, antibiotics and pain medication for temporary relief

If you have any questions about these alternatives or about any other treatments you have heard or thought about, please ask.

POSSIBLE CONSEQUENCES OF NOT COMPLETING TREATMENT PLAN

Advancing decay, Decreased chewing ability, Loss of teeth, Oral pain

WHAT DO I DO NEXT?

Study your packet please. If you have questions please do not hesitate to ask.
Make an appointment to begin care (either today or call the office when you are ready)
Begin using your preventive dental products
Visit with business staff regarding fees and insurance (if applicable)
Fill your prescriptions and begin taking them as directed
Your first appointment will be with our dental hygienist

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PREVENTIVE DENTISTRY RECOMMENDATIONS

4/10/2015

Our goals are to help you keep your teeth in a healthy condition and dental expenses to a minimum. Attempting to prevent dental problems is the key to reaching both goals.

We believe that when patients know their risks for decay and periodontitis (gum disease) and follow advice for reducing the risk their chances for preventing problems are much improved.

After reviewing of your dental history and the clinical examination I have determined your risk levels.

YOUR RISK FOR DECAY: *Moderate caries (decay) risk*

Considerations when assigning caries risk: Cariogenic diet (high sugar intake), Defective dental restoration, Existing caries, Irregular dental care, Suboptimal fluoride exposure, Teeth missing due to caries in the last 36 months

YOUR RISK FOR PERIODONTAL DISEASE (GUM DISEASE): *Moderate periodontal disease risk*

Reasons for periodontal disease risk: Age > 35, Plaque and calculus on the teeth

There are a number of preventive dental care products which can be helpful for keeping your dental problems to a minimum. Based on my findings and your risk assessment I am prescribing the following regimen: **Sonic care tooth brush**

RECOMMENDED RECALL (CLEANING) FREQUENCY: Six month

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GREAT PATIENT

RECOMMENDATION FOR CARE

4/10/2015

I recommend treatment using IV sedation in order to render Great manageable for care in a safe way. At the time of the surgery we will gather the information necessary to create a diagnosis and treatment plan. Following that I will review the findings and make recommendations and we will make every effort to complete the dental care which is necessary and advisable.

GENERAL DENTISTRY PATIENT ACKNOWLEDGEMENT

(TO BE REVIEWED BY APPROPRIATE CAREGIVER IF APPROPRIATE)

Treatment Plan

I understand the recommended treatment and the financial responsibility. I understand that by signing this consent I am in no way obligated to any treatment.

Drug and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

Extractions

I understand removing teeth does not always remove the infection, if present, and may be necessary to have further treatment. I understand the risks 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 surrounding tissue (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges, 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 come off easily and that I must be careful to ensure that they are kept on until the permanent restoration is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. Excessive delay in the permanent cementation of crowns or bridges may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Endodontic Therapy

I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to restore it.

Periodontal Disease

I understand that if I have been diagnosed with a condition causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. I understand that periodontal surgery is intended to strengthen the

bone support of teeth or improve the health of the gum tissue. Success of periodontal surgery requires my strict maintenance of oral home care and compliance with the recommendations of the dentist and dental staff.

Fillings
I understand that care must be exercised in chewing on filling teeth, especially during the first few hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity sometimes occurs following a newly placed restoration.

Partials and Dentures
I understand the wearing of partials/dentures is difficult in the beginning: sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful at first and may require considerable adjusting and several relines. A permanent reline will be needed at a later date. I understand that it is my responsibility to return for delivery of my partial/denture and that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay an additional charge could be incurred.

Dental Implants and Implant Prosthetics
I understand that dental implants are artificial devices placed into the bone in my jaw/s to support replacement teeth. I further understand that the risks associated with the surgical placement of implants are separate from the restoration of the implants and its associated risks.

I understand that the number, size, and position of the implants depend on the amount and availability of bone in my jaws, and that these factors may influence or limit the restoration of the implants in ways which may cause the restoration to vary from an ideal situation.

I further understand that there may be some unwanted complications associated with restoration of my implants, some of which are damage to nearby teeth and restorations, infection, gum tissue swelling, sensitivity and/or pain, disagreement with aesthetic results (appearance), breakage of prosthesis, retaining screws, implants, or any components of the restoration and failure of the integration of the implant/s to the bone.

GREAT PATIENT

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to my health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I understand that dentistry is not an exact science and therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

I have received information about the proposed treatment. I have discussed my treatment with Tom F. Cockerell, Jr., D.D.S. and have been given an opportunity to ask questions and have them fully answered. Photographs of my face and oral cavity may be taken and stored for my dental record.

I authorize Tom F. Cockerell, Jr., D.D.S. or assistants as may be designated to perform those procedures as deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for whom I have responsibility, including arrangement and/or administration of any analgesic, therapeutic, and/or other pharmaceutical agent(s) related to restorative, palliative, therapeutic or surgical treatments.

I wish to proceed with the recommended treatment.

Signed:_____

Date:_____

Parent or Guardian

_____

Date:_____