COLUMBIA DENTAL
1807 WILSHIRE BLVD SUITE A
SANTA MONICA, CA 90403
TEL: 310-453-5436

ALERT!

Bisphophonate Drug Notification

Please notify us if you are taking any of the following drugs in the bisphosphonate family.

Fosomax® (Aldendronate)

Bonefos®. Ostac® (Clodronate)

Didronel® (Etironate)

Boniva® (Ibandronate)

Aredia® (Pamidronate)

Actonel® (Risedronate)

Skelid® (Tiludronate)

Zometa® (Zoledronate)

☐ Yes, I am taking the above medication _____

☐ No, I am not taking any of the above named medications.

Patient or Parent (If under 18) Signature Print Name Date

Columbia Dental Group
Consent Form

1. WORK TO BE DONE

I understand that I am having the following work done Filling(s) ___ Bridge ___ Extraction(s) ___ Impacted teeth(s) removed ___ Root Canal(s) ___ Other ___.

2. DRUGS, MEDICATIONS, AND ANESTHETICS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of the tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Anesthetic can also cause partial (paresthesia) that can last for an indefinite period of time (days/months).

Date: ____ Initials: ____

3. CHANGES IN TREATMENT PLAN

I understand that during any treatment it may be necessary to change or add procedures because of condition found on the tooth that were not discovered during examination, the most common being root canal therapy following routine restorative procedure. I would like for the dentist to inform me of any changes before deciding any procedures.

Date: ____ Initials: ____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery) and I authorize the dentist to remove the following teeth ___. I understand removing teeth does not always remove all the infection. If present it may be necessary to have further treatment. I understand the risk in having teeth removed, some which cause pain, swelling, and spread of infection, dry socket, loss feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fracture jaws. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost which is my responsibility.

Date: ____ Initials: ____

5. CROWNS, BRIDGES, AND CAPS

I understand that sometimes it is not possible to match color of natural teeth. I 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 until the permanent crown(s) are delivered. I realize that final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

Date: ____ Initials: ____

6. COMPLETE/ PARTIAL DENTURES

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. I realize the final opportunity to make changes in my new denture (including shape, fir, size, placement, and color) will be in the teeth wax try-in visit. I understand that most dentures require reline approximately three to twelve months after initial placement the cost for this procedure is not included in the initial denture fee.

Date: ____ Initials: ____

7. 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. I understand that occasionally additional surgical procedure may be necessary following the root canal treatment (apicoectomy).

Date: ____ Initials: ____

8. PERIODONTAL LOSS (TISSUE & BONE)

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

Date: ____ Initials: ____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge there are no guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practioner and is individual responsible for dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for the dental treatment.

Signature is for check up and cleaning for the new patient. **Signature:** _____ **Date:** _____

Doctor: _____ **Witness:** _____ **Date:** _____

Financial Responsibility & Agreement

I understand that the patient's ESTIMATED COPAY provided by the office is only an estimate, based on the information provided by the insurance representative. It is not a guarantee to be the exact final copay. The exact final copay amount can only be determined after the claim is processed, paid for, or denied by the insurance. I'm responsible for paying any remaining balance that is determined to be "responsible by the patient" after the claim is processed.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Columbia Dental Group
1807 Wilshire Blvd Suite A
Santa Monica, CA 90403

To our entire patients with H.M.O and preferred dental insurance. This is to inform you of our policies regarding your dental coverage. Please read all of the literature by our company regarding your dental coverage.

All of the H.M.O & P.P.O programs have co-payments for certain procedures. That co-payment is due at the time of service that has begun. There is also a charge for missed appointments without FOURTY-EIGHT hour advanced notification. If you need to cancel your appointment you can leave a message at any time with our answering machine, and we will gladly return your call. The fees for dental procedure and missed appointments vary with each particular insurance policy and it is your responsibility. If you have an appointment schedule for a procedure that has a co-payment and you do not have the co-payment with you, you will not be seen for that appointment. We also strongly recommend you to be familiar with your exclusions and limitation of your dental plan.

According to the dental practice act, health and safety code 1795.12. All x-rays and records belong to dentist (NOT THE PATIENT). The patient however is entitle to a copy which we need a written request letter for any duplication of records and/or x-rays. There is a charge for duplication. The office is required to have all duplication ready with in fifteen days after receiving the payment for duplication.

If you have any question regarding any information, please feel free to talk it over with any front office personal.

Thank you in advanced for your cooperation.

Signature_____ Date_____