

**INFORMED CONSENT (for diagnostic procedures)**

Patient's name \_\_\_\_\_ Date \_\_\_\_\_

***Periodic (POE) and Comprehensive (COE) diagnostic procedures***

As part of your complete examination, we will look at and feel many of the structures of your head, neck, mouth, and teeth in order to evaluate their condition.

We will use a blunt probe under the gums next to your teeth to screen for the presence of gingivitis or periodontitis, gum diseases that can lead to tooth loss.

We will take a full set of up to 18 X-rays in order to show us conditions that are not visible by looking or feeling. Recent original films of acceptable quality may substitute only if you can bring them with you. Where appropriate, we may supplement or substitute for the full mouth X-ray series with a "panoramic" X-ray which covers a broader area, and better relates oral structures to one another.

If possible, we will use modern digital X-ray processes that can reduce your radiation exposure by up to 90%.

Depending on our other findings in these initial examinations, we may also require models or photographs to give us complete information. The models may be mounted on a jaw simulator to reproduce the chewing motion of your jaw.

***Benefits, alternatives, and common risks***

Only with complete information can we develop an accurate diagnosis. There is no effective alternative to these diagnostic procedures. There are no substantial risks from these procedures, though occasional minor discomfort may be experienced by some patients. Risks associated with X-rays are always a concern, but modern equipment ensures a negligible exposure.

***Consequences of not performing these procedures***

Inadequate diagnosis may cause future pain, greater expense for later treatment, loss of teeth, and medical risk.

Every reasonable effort will be made to ensure that your diagnosis is completed properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed diagnostic procedures, that you understand this information, and that all of your questions have been answered fully. You also give permission for information gained from your examination to be used in clinical and economic research, practice marketing, and patient education activities and materials, provided that your identity is not reasonably discernible.

\_\_\_ I give my consent for the proposed diagnostic procedures as described above.

\_\_\_ I refuse to give my consent for the proposed diagnostic procedures as described above. I have been informed of the potential consequences of my decision to refuse complete diagnosis.

\_\_\_\_\_  
Patient's signature / Date

\_\_\_\_\_  
Staff signature / Date