MAXWELL DENTAL

Statement of Informed Consent

Date:_____

Name: _____

An agent of Maxwell Dental will discuss the fact that there are alternatives to the procedures listed, some of which may be recommended or preferred by current dental leadership. Nonetheless, due to a combination of aesthetic, personal and other considerations, it is my individual decision and consent to have these procedures performed.

I understand that NO CURE OR ALLEVIATION OF SYMPTOMS WILL BE PROMISED!

I understand the main objective of treatment is the elimination of identifiable materials to which I will be shown to react to immunologically by the Serum Compatibility Test, if I choose to have it. Extensive reconstruction of my mouth may not be possible at this time due to limited time available and/or my body's ability to handle the extent of work necessary. I understand nothing is permanent. Some of the new restorations in my mouth may require periodic maintenance due to the nature of the material.

Dental Procedures cannot ethically be guaranteed due to the extreme variability in diet, environment and self-care of clients. The dentist will evaluate and re-treat damage to physical restorations on a case by case basis. If I choose to have the Serum Compatibility Test, I understand the limitations imposed by the use of the Serum Compatibility Test and the materials selected from the test results may not be mechanically or physically ideal. However, the materials selected meet the immunological requirements of my body, where possible. I understand the choice of biocompatible materials is the first and highest priority of this treatment even though physically superior materials may exist. I understand failure of these materials may incur further costs to me.

I understand, if my blood pressure exceeds 160/100, I will not be able to receive dental treatment and if my blood pressure exceeds 180/110, I will not be able to receive dental hygiene treatment.
_____ **Initial**

I understand I may leave this clinic with some temporary restorations that will need to be addressed in the future. I understand that additional dentistry may be required at a future date and I understand the need for ongoing care and maintenance and costs associated with such care and maintenance.

The treatment of periodontal disease (gum and bone disease) prevention through regular dental hygiene visits and temporo-mandibular joint disorders (TMJ) is generally of a long-term nature and must be treated separately from the restorative issues. The dentist or hygienist will explain the recommended interval for my individual care. I understand that regular dental hygiene care does not guarantee freedom from dental or oral disease but aids in early detection and prevention of such. It will be explained to me and I understand there are inherent risks associated with regular dental hygiene care including, transient sensitivity, inflamed tissue, and fatigued muscles and joints.

The inherent risks associated with the replacement of restorations include but are not limited to: loss of tooth structure, sensitivity to hot, cold, or chewing pressure (may last days, weeks or even months) and/or damage to the nerve of the tooth requiring further treatment such as root canals (endodontic therapy) or extraction if necessary.

The inherent risks associated with the extraction of teeth or the treatment of NICO (cavitations) includes but is not limited to: painful healing (dry socket), loss of blood, sinus exposure or perforation, nerve damage (short term, long term or permanent), infection and bone chips. The treatment of these problems may incur further expense. I understand I will be responsible to pay for further treatment if necessary.

I understand it is my informed decision for all treatment and any questions concerning the treatment plan co-developed with an agent of Maxwell Dental, and agreed to by me. I have read this statement and fully understand it. I understand the protocol used in the treatment plan is based on information gathered from various sources, most notably the International Academy of Oral Medicine and Toxicology (IAOMT) and the IAOMT'S Scientific Review, and the International Association of Mercury Free Dentists.

I authorize the use of my dental study models and photographs, excluding any personal information, for the use of publication or lectures by Dr. Greff or agents of Maxwell Dental.

I am here on my own behalf and not as an agent for federal, provincial or local regulatory agencies or associations and I am not seeking information under cover of false identity or misrepresentation of my situation or on a mission of entrapment. Further, I have agreed to proceed with the treatment plan of my own accord without promise or assurance of the efficacy of this treatment given by agents or staff of Maxwell Dental

Signed:_____ Date:_____

Witnessed: _____ Date:_____

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