General & Implant Dentistry

Record of Discussion & Informed Consent for Cone Beam Computerized Tomography Scan for a Prescribing Dentist

PATIENT'S NAME ____
Last First Initial

Date of Birth ____

I HEREBY AUTHORIZE: MARK D. EVANS, DDS

AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS, TO PERFORM UPON ME A CONE BEAM DENTAL EXAMINIATION AS PART OF MY DENTAL CARE AND TREATMENT.

General description of procedure:
A CBCT scan is usually referred to as cone beam computerized tomography. This is an x-ray technique similar to a medical CT scan. The technique produces images of your body that depicts internal structures in cross sections rather than the overlapping images typically produced by conventional x-ray exams. Conventional x-rays of your mouth limits your dentist to evaluating anatomical structures in a 2 dimensional view. Your diagnosis and treatment planning can be enhanced by a more complete understanding of complex 3 dimensional anatomy. The relationship of anatomical structures in three dimensions is important in assessing your condition as well as treatment planning for dental implants, surgical extractions, endodontic treatment, oral surgery or advanced dental restorative procedures. CT scans may be useful in evaluating and potentially diagnosing conditions which cannot be properly seen with conventional x-rays.

Risks:
CBCT scans, like conventional x-rays expose you to radiation. The dose is approximately the same as U.S. background radiation equivalents: 1 day for upper teeth, 3 days for the lower front teeth and 5 days for lower back teeth.

The Cone Beam dental examination may or may not reveal coincidental medical findings unrelated to my dental condition, dental care and dental treatment. The purpose is a diagnostic procedure intended solely to facilitate diagnosis to my dental condition, my dental care, and my dental treatment.

The Cone Beam dental examination will be evaluated solely for the purposes associated with the dental procedures discussed in your treatment plan. The data obtained during this study may result in incidental findings unrelated to my dental condition, dental care and dental treatment and are beyond the scope and purpose of my dental condition. Your dentist is not a physician or a specialist qualified to make the assessment concerning anatomy and pathology beyond your mouth and jaw. As a result, you may elect to have the data evaluated by a physician or radiologist. I understand that my dentist Dr. _____________is prescribing the Cone Beam dental scan from Dr. Mark D. Evans. I also have been told that I may elect to send the CT studies on my

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behalf to a head and neck radiologist to evaluate the study for additional findings outside the scope of my dental exam. The cost associated with this additional interpretation will be beyond the fees charged for the CBCT scan itself.

CBCT scans are NOT recommended for pregnant women because of danger to the fetus. (Initial below as appropriate.)

___ I am not pregnant
___ I am pregnant
___ I am unsure whether I am pregnant

Alternatives:
An alternative to CBCT scans are conventional X-rays, however, they have limitations previously noted.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatment and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I realize CBCT is appropriate and desired by me. I am aware that the diagnostic imaging procedure which I will undergo may potentially reveal pathology outside the scope of my dentist's expertise and the information provided does not guarantee a specific diagnosis or clinical outcome. I acknowledge that no guarantees have been made to me concerning the results of the diagnosis or the proposed clinical procedure.

I have provided as accurate and complete a medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to permit and me prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatment and procedures, prior to signing this form.

I give permission and consent to Dr. Evans to share clinical images taken from this study with other persons for the purpose of gaining additional insight on my clinical condition, for educational purposes and/or the development of the medical/dental field.

PATIENT OR GUARDIAN SIGNATURE____
Date

DENTIST'S SIGNATURE____
Date

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