Michael J. Williams, D.M.D., P C
120 South Street
Pittsfield, MA 01201

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(413)442-7855
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Patient Name: Last | First | MI | Preferred Name

LANAP Consent and Authorization for Treatment

Treatment Needed: (Quadrant)

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1. I understand that dental lasers marketed and sold in the United States have been cleared for marketing by the Food and Drug Administration (FDA) for use in dentistry.

2. I understand that Dr. Williams has been trained extensively in the use of dental lasers by the best universities, academics and experts that teach this information.

3. I have been presented with the laser treatment plan and fees for treatment. I have been informed of other methods of treatment and the alternatives. The expected results and risks (even the remote chance of death) of the proposed treatment (and/or no treatment) have been explained to me.

4. I understand there is no guarantee of success or permanence of the treatment.

5. I understand that dental conditions in my mouth can change and alter the proposed treatment plan.

6. I understand that any time teeth are manipulated, wether by a mechanical drill or laser, there is always, the possibility and risk that root canal therapy may be necessary. I realize that in spite of observing every reasonable precaution-prior nerve damage, infection, or tooth trauma may have pre-existed in the tooth.

7. I understand that anytime that soft tissue is manipulated, wether by traditional dental technology, or laser dentistry, there is always a possibility and risk of unexpected and undesirable side effects.

8. "Spaces" between your teeth can result from reduction of inflammation, swelling, and the removal of diseased tissue after the LANAP treatment. These spaces usually fill in over time, and again, bite adjustment is critical to making sure the teeth and the "papilla" are not traumatized and can regrow.

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9. "Occlusal adjustment" and "occlusal equilibration" has been fully explained to me. I have had the opportunity to ask questions, and I fully understand that occlusal adjustments and equilibration require 100% cooperation and compliance. It has been explained to me that failure to complete all phases of occlusal adjustments and equilibration may result in oral-facial pain, temporomandibular joint dysfunction (TMJ), sore and painful teeth, and it has been explained to me that until the teeth have been fully adjusted and/or equilibrated, I may experience transitional TMJ pain, muscle soreness, headaches, tooth pain, tooth sensitivity, and cheek biting. I understand adjusting crowns can remove porcelain, expose metal and/or tooth structure, and may require the replacement of any and all crowns.

10. I understand that dental cleanings are absolutely necessary every 3 months for the procedure to be successful. These cleanings should be done in Dr. Williams' office for the first year and then I will need to alternate between Dr. Williams' office and my general dentist.

11. I understand that insurance reimbursement is only an estimate. I am ultimately responsible for any fees incurred during treatment. I understand this office does not operate on the assumption that insurance will reimburse me for the treatment rendered.

12. I understand that this office is performing this treatment in my own best interests.

13. I have read and agreed to foregoing. I have had the opportunity to ask treatment related questions and have been advised of the risks and benefits of treatment, including the use of local anesthesia and dental lasers.

14. I understand that it is necessary to complete all phases of the recommended treatment, and agree to do so.

15. I authorize the performance, upon myself, of dental treatment using dental lasers, which treatment will be performed by Michael J. Williams, DMD

Response Date: _____