

DENTAL TREATMENT CONSENT FORM

Patient Name _____ Birthdate _____

Please read this form and sign the section at the bottom of form.

WORK TO BE DONE: I understand that I am having Fillings, Crowns, Bridges, Extractions, Root Canals, Dental Cleanings, Dentures, and Partial.

DRUGS AND MEDICATIONS: I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery), and I authorize the Dentist to remove any necessary teeth. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

CROWN, BRIDGES AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further 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 on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, and color) will be before cementation.

DENTURES, COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problem of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize my final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures require relining approximately six to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

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 tooth, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal therapy (Apicoectomy).

PERIODONTAL LOSS (TISSUE & BONE): I understand that this is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacements, and/or extractions). Any dental procedure may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Signature of Patient, Parent, or Guardian

Date