DENTAL TREATMENT CONSENT FORM

Please read, initial the items, and sign at the bottom of form.

Patient Name: _____

1. DIAGNOSTIC AND PREVENTIVE
I understand that I am having the following work done:
X-rays _____ Cleaning _____ Scaling _____ Fluoride _____
Sealants _____ (Initials_____)

2. DRUGS, MEDICATIONS AND LOCAL ANESTHETICS
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling, or numbness that may persist for several weeks, months, or rarely, be permanent. I have informed my dentist of my complete medical history, including any recent surgeries, changes in my medical history, and any known allergies. (Initials_____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following 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. (Initials_____)

5. CROWNS (CAPS) AND BRIDGES
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, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge. (Initials_____)

6. DENTURES, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the 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 three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

7. 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. I understand that root canals can fail and may require additional treatment or I may end up having the tooth extracted. I also understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

9. FILLINGS
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs. (Initials_____)

10. DENTURES
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials_____)

Signature of Patient or Legal Guardian _____ Date_____