Dentist 4
better quality of life

DENTAL TREATMENT CONSENT FORM

Patient's Name:_____ Dentist's Name: _____

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

◯ **X-RAYS** Initials( )

◯ **DRUGS AND MEDICATIONS**
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, drowsiness, vomiting, dizziness, or in rare cases anaphylactic shock. Initials( )

◯ **CHANGES IN TREATMENT PLAN**
I understand that during the course of the treatment, unforeseen conditions may arise and will cause an extension or modification of the planned procedures contained herein and in the Treatment Plan presented to me. I therefore authorize and request that the dentist and his associates or assistants under his direction perform such procedure as found necessary and administer such treatments as required in their professional judgment. Initials( )

◯**FILLINGS** **Tooth#:**_____
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. Initials( )

◯ **PERIODONTAL SCALING AND ROOT PLANING**
This treatment may result in unintended consequences (bleeding, infection, tissue swelling or bruising, increased sensitivity to hot/cold/sweets, esthetic changes, exposure of crown margins, exposed root surfaces due to recession of gum line, pain in the associated teeth including roots, temporary or permanent numbness, and tooth mobility or loss). I understand that my own efforts with home care are just as important as my professional treatment.
Initials( )

◯**REMOVAL OF TEETH** **Tooth#:**_____
Alternatives to extraction have been explained to me (root canal therapy, crowns, and periodontal surgery, etc). I authorize the dentist to remove the teeth mentioned above and any others necessary for reasons in paragraph No. 3. I understand that 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( )

◯**BONE GRAFTING** **Tooth#:**_____
I understand that the bone is taken from a bone bank (cadaver, bovine, or synthetic). The grafted site takes anywhere from 4-8 months to heal. After that time, it may be necessary to refine the area. I acknowledge that in some cases, additional grafting may be required. Initials( )

◯ **CROWNS 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. Initials( )

◯ **DENTURES**
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 (looseness, soreness, altered speech, difficulty in eating, and possible breakage). I realize the final opportunity to make changes in my new denture (including shape, fit, size, and color) will be in the "Teeth in Wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be painful. I understand that most of the dentures require adjustments and several relines approximately three to twelve months after initial placement. The cost for these procedures is not included in the initial denture fee. I understand 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( ).

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, which have been answered to my satisfaction. I consent to the proposed treatment.

_____ Date: _____
Signature of Patient/Parent/Guardian

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