DENTAL TREATMENT CONSENT FORM

Patients Name: _____ Date of Birth: _____
Doctor Name: _____

☐1. X-RAYS:

(Initials _____)

☐2. 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). (Initials _____)

☐3. 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 restoration procedures. I give my permission to the dentist to make any/all changes and additions as necessary. (Initials _____)

☐4. REMOVAL OF 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. 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 and any others necessary for reasons in paragraph #3. (Initials _____)

☐5. CROWNS, 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 on my new crown, bridge or cap (including shape, fit, size and color) will be before cementation. (Initials _____)

☐6. DENTURES, COMPLETE OR PARTIAL:

I understand 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 to 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 understand 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 root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apiceoectomy). (Initials _____)

☐8. PERIODONTAL LOSS (TISSUE & BONE):

I understand that in the event I am diagnosed with Periodontial Disease, periodontial therapy will be needed for definitive treatment. Which includes scaling and root planning, periodontial maintenance and subgingival antibiotic medicament will be placed if deemed necessary. (Initials _____)

☐9. FILLINGS:

I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I also 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 _____)

☐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 this 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 patient delays of more than 30 days there will be additional charges. (Initials _____)

☐11. REQUIRED 30% DEPOSIT ON TREATMENT:

I understand that a 30% deposit will be required on all dental treatment prior to scheduling the appointment. (Initials _____)

I understand that dentistry is not an exact science and that, 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 authorize. I have had the opportunity to read this form and ask questions. All questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient / Parent / Guardian Signature: _____ Date: _____
Doctor Signature: _____ Date: _____