DENTAL TREATMENT CONSENT

Name ----------Office ----------

• TREATMENT TO BE DONE **Initials** ----------

I understand I am having the following treatment: ◯ Exam/X-rays ◯ Fillings ◯ Bridges ◯ Crowns ◯ Extractions ◯ Root canal ◯ Sealants ◯ Bleaching ◯ Fluoride ◯ Impressions ◯ Other ----------

• DRUGS & MEDICATION: **Initials** ----------

I understand that antibiotic, analgesic, & other medications can cause allergic reactions causing redness, swelling of tissue, pain, itching, vomiting and/or anaphylactic shock *(severe allergic reaction)*.

• CHANGES IN TREATMENT: **Initials** ----------

I understand that during treatment it may be necessary to change or add procedures due to 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 & additions as necessary.

• REMOVAL OF TEETH: **Initials** ----------

Alternatives to removal have been explained to me *(root canal therapy, crowns, periodontal surgery, etc.)* & I authorize the dentist to remove the recommended teeth & any others necessary due to a change in treatment plan. I understand removing teeth does not always remove all of the infection, & 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, & surrounding tissue *(Paresthesia)* that can last for an indefinite period of time *(days, months, or in rare cases permanently)* or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complication arises during the following treatment, the cost of which is my responsibility.

• CROWNS & BRIDGES: **Initials** ----------

I understand that sometimes it is not possible to match the color of natural looking teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns which may come off easily & 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 or bridge *(including shape, size, fit, color)* will be before cementation. I understand that if I do not return for my scheduled appointment for delivery of my crown or bridge, it may not fit properly & I will be responsible for any lab fees incurred if a remake becomes necessary.

• DENTURES (complete or partial): **Initials** ----------

I realize 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, & possible breakage. I realize the final opportunity to make changes in my new denture *(including shape, size, fit, & color)* will be the "teeth in wax" Try-In visit. I understand most dentures require relining approximately 3-6 months after initial placement & yearly thereafter. The cost for these relines is not included in the initial denture fee.

• ENDODONTICS (root canal): **Initials** ----------

I realize there is no guarantee that root canal therapy will save my tooth & complications can occur *(pain or infection)* from the treatment. I further realize that occasional root canal filling material may extend through the root or it may not be possible to completely fill the root. I understand that occasionally additional surgical procedures may be necessary following root canal therapy *(apicoectomy)*.

• PERIODONTAL LOSS (tissue & bone): **Initials** ----------

I understand that I have a serious condition & my dentist has advised me to have a consultation with the Periodontist. I understand that not undertaking periodontal care may have an adverse effect on my periodontal condition & could lead to loss of my teeth.

I understand that dentistry is not an exact science & therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested & authorized. I understand that each dentist is individually responsible for the dental care rendered to me.

Signature ---------- Date ----------

Doctor ---------- Witness----------