DENTAL TREATMENT CONSENT FORM

PATIENT NAME:_____ DATE:_____

☐ **Work To Be Done**
I understand that I am to have work done as detailed in the attached treatment plan. Initials_____

☐ **Drugs And Medication**
I understand that antibiotic, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, and vomiting and/or anaphylactic shock (severe allergic reactions). I have informed the dentist of any known allergies to medication. Initials_____

☐ **Changes In Treatment Plan**
I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination. For Example, root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Initials_____

☐ **Removal of Teeth**
Alternatives to removals have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and I authorize the dentist to remove the following tooth #_____ and any others necessary for reasons in paragraph #3. 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 sockets, exposed sinuses, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise, the cost of which is my responsibility. Initials_____

☐ **Crown and Veneers**

A. Treatment involves covering the above the gum line with a cap (crown) or covering the front surface of the tooth with a tooth colored bonded porcelain laminated called veneer. I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing a temporary crown, which comes off easily with artificial teeth. I further understand that I may be wearing a temporary crown, which comes off easily with artificial teeth. I must be careful to insure that they are kept on until the permanent crowns are delivered. I realized the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive days may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remark of the crowns, bridge, or veneer. I understand there will be additional charges from remarks or other treatment due to my delaying permanent cementation. Initials_____

B. I am electing to do a fixed bridge, removable appliance, implant (circle one) for replacement of missing teeth.

☐ **Endodontic Treatment (Root Canal Therapy)**
I realize there is no guarantee the root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally the canal filling material may extend through the root tip, which does not necessarily affect the success of the treatment. Hard to detect root fractures are one of the main reasons why root canals fail. Since teeth for root canal are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. It also prevents a root canal from being re-infected. I understand that the tooth may be lost in spite of all efforts to save it. Initials_____

☐ **Periodontal Loss (Tissue and Bone)**
I understand that I have a serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that periodontal disease may have a future adverse effect on the long-term success or dental restorative work Initials_____

☐ **Fillings**
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that sensitivity is a common effect after a newly placed filling. Initials_____

☐ **Dentures, Complete Partial**
I realize that full or partial dentures are artificial, constructed or plastic, metal and/or porcelain. The problem of wearing these appliance 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. Immediate denture (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not including in the initial denture fee. I understand that it is my responsibility to return for my delivery of dentures. I understand that failure to keep delivery appointment may result in poorly fitted dentures. If remake is required due to my delay of more than 30 days, there will be additional charges. Initials_____

☐ **Bleaching**
Bleaching is a procedure done either in office (1 hour) or with take home trays (2 weeks). The degree of whitening varies with the individual. The average patient achieves considerable changes (1-3 shades on dental shade guide). Coffee, tea, and tobacco, will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of teeth and/or gums inflammation, which will subside when treatment means accepted of risks. Pregnant women are advised to consult with their physicians before starting treatment. Initials_____

☐ **Nitrous oxide**
I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand possible side effects that may occur. These include, but are limited to nausea, vomiting, dizziness, and headache. I also understand that nitrous oxide use is not indicated if I am pregnant. Initials_____

☐ **Dental Benefits**
I understand that my insurance may provide only the minimum standard of care. I elect to follow the doctor's recommendation optional dental treatment including all cosmetic procedures. Initials_____

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

Signature of Patient or Legal Guardian **Date**