DENTAL TREATMENT INFORMED CONSENT

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

1. WORK TO BE DONE
I understand that I am having the following work done: Exam _____X-ray_____Prophylaxis_____

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 restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. FILLINGS
I have been advised of the need for filling(s), either silver amalgam or composite (plastic, resin), to replace tooth structure lost to decay. I understand that with time, fillings will need to be replaced due to wear of material, new decay on the tooth involving additional surfaces, or fracture. In cases where very little tooth structure remains, or existing tooth structure fractures or falls off, I may need a more extensive procedure completed to adequately restore the tooth, (i.e. root canal, post, build-up, crown, etc.), necessitating an additional charge. I understand that significant sensitivity is common after a new filling is placed and can remain so for several weeks.
(Initials_____)

5. 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 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 socket, broken roots, 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_____)

6. CROWN, 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. Should I lose a temporary and not have it re-cemented within a few days or if I delay permanent cementation beyond 2 months. I understand that the crown/bridge may need to be remade, the cost of which is my responsibility. 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_____)

7. 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 the procedure is not included in the initial denture fee.
(Initials_____)

8. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications including but not limited to pain, infection, tooth breakage and tooth loss, can occur from the treatment, and that occasionally metal and non-metallic 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 and/or referral to a specialist may be necessary following root canal treatment. (Initials_____)

9. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical therapies, gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (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 that 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 and I understand my alternatives. I consent to the proposed treatment and accept the risks involved. I request and authorize any of the doctors and staff to perform dental work upon me (or the person for whom I am parent/guardian)

Signature of Patient _____ Date: _____

Signature of Parent/Guardian, if patient is a minor _____ Date: _____

Doctor _____ Date: _____

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