DENTAL TREATMENT CONSENT FORM

Patient's Name_____

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

1. X-RAYS I have been informed that x-rays are used to help find cavities between teeth that are not visible clinically. They are also necessary to detect infection and abscess in the bone. Although our digital x-rays expose patients to significantly less radiation (up to 90% less) than traditional x-rays, they still result in some exposure. Because of this, we do not take x-rays on pregnant women unless absolutely necessary, for emergency treatment, so please tell us if you are pregnant or trying to become pregnant. (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. ANESTHESIA I understand the risk involved in receiving local anesthetic, some of which are partial facial paralysis; inflamed tissue; adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage; and/or numbness. (Initials_____).

4. 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 indirect or direct pulp cap, or root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (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 Dentists to remove the following teeth and any others necessary. 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, damage to adjacent teeth, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissues (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. 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 in my new crown, bridge or cap (including shape, fit, size and color) will before permanent 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, gagging, 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 this 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 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 (apicoectomy). (Initials_____).

9. FILLINGS 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 than 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 is is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to delays of more than 30 days, there will be additional charges. (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 authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____Date_____

Signature of Parent/Guardian if patient is a minor_____Date_____