

Consent for Dental Treatment

Patient's Name----- Date-----

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

1_____. **TREATMENT:**

I understand I am having the following dental treatment performed:

- Fillings Sealants Crowns Bridges Dentures Extractions (Extraction Consent)
 Root Planing Root Canals (RCT Consent) Other:

2_____. **Drugs and Medications:**

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions, including heart irregularities. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs. I understand that pain medications are meant to dull the pain and take the edge off.

3_____. **Sealants: Teeth:**

I understand that sealants are meant to help protect a tooth and to help prevent decay on the chewing surface of a tooth. A sealant is not guaranteed protection from decay. They may wear out and/or chip and are typically not covered by insurance.

4_____. **Fillings: Teeth:**

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I realize that fillings are rarely "permanent" and usually require periodic replacement. **I understand any time a tooth is prepared, for any reason, there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring root canal treatment or removal of the tooth.** It is difficult to predict how your tooth may respond. This may not be determined until preparing a tooth for a filling or if post operative symptoms persist.

5_____. **Crowns and Bridges: Teeth:**

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final

restoration is delivered. I understand that crowns and bridges are not permanent and may require replacement in as little as three years and that brushing, flossing, and regular cleanings are essential. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final placement of the restoration. I understand I may need additional treatment if complications arise during treatment, and any costs thus incurred are my responsibility. Additionally, I understand that it is my responsibility to return within one month for a check to ensure that the crown or bridge has been placed to my satisfaction.

6_____. **Dentures:** I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable during and after healing. Immediate dentures require frequent adjustment and one or more relines within days to several months. I understand it is possible that after healing is finished, the denture may need to be remade and additional fees may be incurred. Failure to make and keep my follow-up appointments may result in a less desirable outcome. A permanent reline will be necessary in approximately six months and will result in an additional charge.

7_____. **Extractions (See Consent for Extraction of Teeth):** Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. It is my understanding that the following teeth will be removed: . I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness is rare and usually has to do with where the teeth are situated in relation to your nerves, but may be temporary or permanent.

I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

8_____. **Periodontal Treatment :** Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of cleaning appointments. I understand that care by a specialist may be necessary.

9_____. **Root Canal Therapy (See Consent for Root Canal Treatment):
Teeth:**

I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. I understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise, such as the need for an apicoectomy.

10. Changes in Treatment Plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my financial responsibility.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's (or Legal Guardian's) Signature _____ Date _____

Witness' Signature _____ Date _____