Dental Treatment Consent Form

Please read, initial next to the marked items, and sign below

1. **Medications & Anesthetics**
   I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Initial:_____
2. **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, the most common being root canal therapy following routine restorative procedures. Initial: _____
3. **Removal of Teeth #_____**
   I understand that sometimes removing teeth does not always remove all of 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 infection, dry socket, sinus, perforation; nerve damage in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time, fractured jaw, retained root tips, and fracture(s) of adjacent teeth or restorations. I understand I may need further treatment. Initial:_____
4. **Crowns & Bridges #_____**
   I understand that sometimes it is not possible to match the exact color of natural teeth to artificial teeth. I further understand that I may be wearing temporary crown, which may come off easily and that I must be careful to ensure that they are kept until the permanent crowns are delivered I realize that the final opportunity to make changes in my crown, bridge or cap (including shape, fit, size and color) will be before cementation. Initial_____
5. **Filings & Build-ups #_____**
   I understand that care must be exercised in chewing. I understand that more involved restorative treatment may become immediately necessary, should it be determined that there is not adequate natural tooth structure remaining to support a tooth colored bonded filling. Additionally, larger more extensive fillings may eventually need additional treatment including root canal therapy and/or crown. I understand that sensitivity is a common and short-term symptom after placement of a new bonded tooth-colored restoration. Intitial_____
6. **Dentures or Partial _____**
   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems associated with 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 partial dentures require relining or remaking approximately three (3) to twelve (12) months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand the wearing of dentures is difficult and may require adjustment to improve comfort. Initial_____
7. **Root Canal Therapy #_____**
   There is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment. One complication would be to leave the piece of the file only if the retrieval were the only possible with extensive surgical procedures and if leaving the instrument will not hinder the success of the treatment. I understand the occasional additional surgical procedures may be necessary following root canal treatment (apicoectomy). Initial_____

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 in which I have requested and authorized. I understand that each dentist is an individual practitioner and individually responsible for the dental care rendered to me. Treatment benefits, possible complications, related risks and alternatives have been thoroughly explained to me. 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.

Name (Print): _____

Signature/Guardian: _____

Doctor: _____ Date:_____