## **Dental Treatment Consent Form**

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

<ul> <li>1. Medications &amp; Anesthetics</li></ul>		Tiedde Tedd, illiad Tiext to the	O Pantana and Pantial
I understand that antibiotics and other medications can cause allergic reactions causing redeness and swelling of tissue, pain, tiching, vomiting, and/or anaphylactic shock (severe allergic reaction). Initial:  1. 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:  1. Understand that sometimes removing teeth does not always remove all of the infection, if present, and if 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) hat can last for an indefinite period of time, fractured jaw, retained root tips, and fracture(s) of adjacent teeth or restorations. 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.  1. Understand that care must be exercised in chewing, I understand that care must be exercised in chewing, I understand that brome involved restorative treatment may become immediately	1	Madications & Anasthatics	6. Dentures or Partial
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necessary, should it be determined that there is		necessary, should it be determined that there is	• •
not adequate natural tooth structure remaining to Name (Print):			Name (Print):
support a tooth colored bonded filling. Additionally,			\ \
larger more extensive fillings may eventually need Signature/Guardian:			Signature/Guardian:

Doctor: \_\_\_\_\_\_ Date: \_\_\_\_\_

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\_\_\_\_