



**DENTAL TREATMENT CONSENT FORM**

Please read and initial the items checked below

Patient Name \_\_\_\_\_

**WORK TO BE DONE**

I understand that I am having the following work done:

Initial \_\_\_\_\_

Fillings \_\_\_\_\_ Bridges \_\_\_\_\_ Crowns \_\_\_\_\_ Extractions \_\_\_\_\_ Other \_\_\_\_\_

**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).

Initial \_\_\_\_\_

**CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of condition 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 permission to the dentist to make any/all changed and additions as necessary.

Initial \_\_\_\_\_

**FILLINGS**

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during tooth preparation. I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that if my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely “permanent” and usually require periodic replacement with additional fillings and/or crowns. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any cost thus incurred are my responsibility.

Initial \_\_\_\_\_

**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, and some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days of 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.

Initial \_\_\_\_\_

**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 be before cementation.

Initial \_\_\_\_\_

**DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of acrylic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, include 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 of the procedure is not included in the initial denture fee.

Initial \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent/ Guardian \_\_\_\_\_

Date \_\_\_\_\_