DENTAL TREATMENT CONSENT FORM

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

Patient Name: ____________________________

1. DIAGNOSTIC AND PREVENTIVE
I understand that I am having the following work done:
X-rays _____ Cleaning _____ Scaling _____ Fluoride _____
Sealants _____ (Initials__________________)

2. DRUGS, MEDICATIONS AND LOCAL ANESTHETICS
I understand that antibiotics, analgesics and other medications
causing allergic reactions causing redness and swelling of
tissues, pain, itching, vomiting, and/or anaphylactic shock
(severe allergic reaction). I also understand there are risks of
local anesthesia that may affect my body such as dizziness,
nausea, vomiting, accelerated/slow heart rate, or various types
of allergic reactions. It may also cause injury to nerves that can
result in pain, tingling, or numbness that may persist for
several weeks, months, or rarely, be permanent. I have
informed my dentist of my complete medical history, including
any recent surgeries, changes in my medical history, and any
known allergies. (Initials__________________)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to
change and/or add procedures because of conditions found
while working on the teeth that were not discovered during
examination. Upon my consent, I give my permission to the
Dentist to make any/all changes and additions as necessary.
(Initials__________________)

4. 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 ________________.
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,
dry socket, loss of feeling in my teeth, lips, tongue and
surrounding tissue (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__________________)

5. CROWNS (CAPS) AND BRIDGES
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. Once cemented, I understand that any
changes in shape, fit, size, or color will incur an additional
charge. (Initials__________________)

6. 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, 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
two to twelve months after initial placement. The cost for this
procedure is not included in the initial denture fee.
(Initials__________________)

7. 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. I understand that root canals can fail and may
require additional treatment or I may end up having the tooth
extracted. I also understand that occasionally additional
surgical procedures may be necessary following root canal
treatment (apicoectomy). (Initials__________________)

8. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and
bone infection that can lead to the loss of my teeth. Alternative
treatment plans have been explained to me, including gum
surgery, replacements and/or extractions. I understand that
undertaking any dental procedures may have a future adverse
effect on my periodontal condition. (Initials__________________)

9. FILLINGS
I understand that I may experience hot and cold sensitivity,
pain or discomfort following routine restorative procedures and
that this is usually temporary and should settle without further
treatment. If in the event that my condition does not get any
better, I understand that I may need further dental treatment,
the most common being root canal therapy, resulting in
additional costs. (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 it is my responsibility to return for delivery of
the dentures. I understand that failure to keep my delivery
appointment may result in poorly fixed dentures. If a remake is
required due to my delays of more than 30 days there will be
additional charges. (Initials__________________)

Signature of Patient or Legal Guardian ____________________________ Date ____________