OFFICE/PATIENT #_____ / ________________________

NAME________________________

1. TREATMENT TO BE DONE:

2. DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials____)

3. CHANGES IN TREATMENT PLAN:

I understand that during treatment, it may be necessary to change or add procedures due to conditions 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 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, periodontal surgery, etc.), and I authorize the Dentist to remove the recommended teeth and any others necessary due to a change in treatment plan. I understand 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 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, months, or in rare cases, permanently) 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, BRIDGES, AND VENEERS:

I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may 'be wearing temporary crowns, which may come off easily, and 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. I understand if I do not return for my scheduled appointment for delivery of my crown, bridge, or cap, it may not fit properly, and I will be responsible for any lab fees incurred if a remake becomes necessary. (Initials____)

6. DENTURES - COMPLETE OR PARTIAL:

I realize 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 denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. (Initials____)

7. ENDODONTIC TREATMENT (ROOT CANAL):

I realize there is no guarantee that root canal therapy will save my tooth, and complications can occur (such as pain or infection) from the treatment. I further realize that occasionally root canal filling material may extend through the root or it may not be possible to completely fill the root which does not necessarily affect the success of the treatment I 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 and my Dentist has advised me to have a consultation with the Periodontist. I understand that not undertaking periodontal treatment may have an adverse effect on my periodontal condition and could lead to the loss of some or all of my teeth. (Initials____)

9. SEALANTS:

I realize that there is no guarantee with the application of a sealant or sealants on my child. Depending on the child's hygiene, sealants may dissolve or break away from the tooth causing possible decay. (Initials____)

10. SPACE MAINTAINERS:

I understand that a space maintainer is a fixed appliance. I further understand that I am fully responsible to have the appliance checked every 6 months. (Initials____)

11. FILLING/BONDING:

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage.
I understand that a more extensive filling than originally diagnosed may be required due to additional decay.
I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials____)

I understand that dentistry is not an exact science and that therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been:n made by anyone regarding dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Signature:________________________ Date: ________________

Doctor:________________________ Witness:________________