Just for Your Smile

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Consent of Treatment

CONSENT OF TREATMENT: Please read the checked items below, initial to the right, and sign the bottom.

Patient Name: _____ Birthdate: _____ Today's Date: _____

__1) WORK TO BE DONE: I understand that I am having the following work to be done:
Extraction(s)___Crown(s)___Bridge(s)___Veneer(s)___Onlay(s)___Denture(s)___Root Canal(s)___Filling(s)___Scaling and Root Planing___
Other_____ **Initials____**

__2) DRUGS, MEDICATIONS AND LOCAL ANESTHETICS: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand there are risks associated with local anesthesia that may include dizziness, nausea, vomiting, accelerated/slowed 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. **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 and I authorize the Dentist to remove the following teeth _____. I am aware that 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, or fractured jaw. I understand that I may experience loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months). 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, VENEERS AND ONLAYS: 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 restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize the final opportunity to make changes in my new crown, bridge, veneer or onlay (including shape, fit, size and color) will be before cementation. **Initials____**

__6) DENTURES (COMPLETE OR PARTIAL): I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The complications 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 three 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. Complications can occur from the treatment and occasionally separated objects are cemented in the tooth or extended through 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. **Initials____**

__8) COMPOSITE 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 the symptoms do not subside, I understand that I may need further dental treatment, the most common being root canal therapy. **Initials____**

__9) SCALING AND ROOT PLANING: I understand that I have a condition that is causing gum and bone infection and can lead to the loss of my teeth. I am aware that complications following scaling and root planing can include, but are not limited to: bleeding, infection, exposed root surfaces, tooth sensitivity to hot or cold, and tooth mobility. I further understand that if no treatment is rendered, my present periodontal condition will worsen in time, which may result in premature tooth loss. I understand that success requires my long-term commitment to proper daily home care and routine dental care. **Initials____**

I acknowledge that I have read and understand this consent and the meaning of its contents. I have been given the opportunity to discuss and ask questions regarding the dental treatment and all questions have been answered to my satisfaction.

Signature: _____Relationship: _____