PATIENT NAME: ________________________________

1. TREATMENT TO BE DONE:
I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional needed and appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there is a need for a referral to a specialist identified and deemed necessary by my dentist, then the cost of this referral will be my responsibility.

Initials: ____________  Date: ____________

2. DRUGS AND MEDICATIONS:
I understand that antibiotics, analgesics, and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergy to specific medications to avoid possible adverse effects from medication that my dentist will prescribe.

Initials: ____________  Date: ____________

LOCAL ANESTHETICS/SEDATIVES:
The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in the heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to: pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to: permanent numbness, abnormal sensation, transient blindness, and even death.

Initials: ____________  Date: ____________

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 once I have been informed of these changes and consented to them. I also understand that by not following my dentist’s recommendation, delayed treatment can lead to but is not limited to: more discomfort, an increase in the complexity of the treatment outcome or eventual loss of teeth.

Initials: ____________  Date: ____________

4. EXTRactions: (REMOVAL OF TEETH)
I give my consent to the dentist to perform the extractionsurgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable to complete the planned operation/extraction. If left untreated, the risks to my health may include, but are not limited to: swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, premature loss of teeth and/or bone. My dentist has informed me of alternative methods of treatment.
Tooth#: __________  Initials: ____________  Date: ____________

Potential risks of oral surgery include, but are not limited to the following:

A. Post operative discomfort, stretching of the corners of the mouth with resultant cracking and bruising, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage possibly exposing crown margins, tooth looseness, delayed healing, dry socket and/or infection requiring prescriptions or additional treatment (i.e surgery)

B. Injury to adjacent teeth, prosthesis, existing restorations (which may require additional treatment), and/or injury to other tissues or teeth not within the described surgical area.

C. Limitation of mouth opening, stiffness of facial and/or neck muscles, change in bite or temporomandibular joint pain complications.

D. Residual root or bone fragments left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone and/or jaw fracture or opening of maxillary sinus requiring additional surgery.

F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction, calling for the doctor’s judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he or she may deem advisable, including referral to another dentist or specialist.

5. CROWNS, BRIDGES, AND CAPS:
I understand that sometimes it is not possible to match the exact color of natural teeth with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that if my temporary crowns come off, then it is my responsibility to return to return it to my dentist to have it re-cemented. I realize the final opportunity to make changes to my 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 or bridge, they may not fit properly, and I will be responsible for any fees associated with the remaking of the permanent crown/bridge due to such delays.

Tooth#: __________ Shade: __________ Initials: ____________ Date: ____________

6. DENTURES – COMPLETE OR PARTIAL
I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems associated with the wearing of these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes to 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. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachments and/or other complicating factors, I may never be able to wear dentures to my satisfaction.

Shade: __________ Date: __________

7. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)
The purpose and method of root canal therapy have been explained to me as well as consequences of non-treatment and reasonable alternative treatments. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a final restoration (usually a crown) over the tooth. I also understand that sometimes root canal therapy may fail and further treatment may be necessary that might include but is not limited to: retreatment, apicoectomy or extraction of the tooth.

Tooth #: __________ Initials: __________ Date: __________

I understand that treatment risks can include but are not limited to the following:
A. Post treatment discomfort, infection, restricted jaw opening.

B. Swelling of the gum area in the vicinity of the treated tooth, and/or facial swelling, either of which may persist for several days or longer.

C. Separation of root canal instruments during treatment, which may in the judgment of the dentist, be left in the treated root canal or bone as part of the filling material; or it may require surgery for the removal.

D. Perforation of the root canal which may require additional surgical treatment or premature tooth loss (extraction).

E. Risk of temporary or permanent numbness in treatment vicinity.

F. The root canal filling material may be overfilled or under filled, which may or may not affect the success/outcome of the treatment.
8. PERIODONTAL LOSS (TISSUE AND BONE):
I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to loss of my teeth and other related systemic complications. The various treatment plans have been explained to me, including non-surgical scaling and root planning followed by local irrigation with oral medicaments and local delivery of antibiotic, and laser or gum surgery, or replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for a referral to a periodontist.

Initials: ___________        Date: ___________

9. FILLINGS:
I have been advised of the need for fillings. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment such as root canal therapy, post and build-up, and/or crowns, which would necessitate a separate charge. I understand that my recently placed fillings may cause some sensitivity and discomfort that may be alleviated with time. However, I understand that if the symptoms and sensitivity worsen, then I might need Root Canal Therapy.

Initials: ___________        Date: ___________

10. PEDODONTICS (CHILDREN’S DENTISTRY):
I understand the following procedures are routinely used in conjunction with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized caregiver, I understand and give consent that the following procedures can be used on my child:

A. POSITIVE REINFORCEMENT: Rewarding the child who portrays desirable behavior, by use of compliments, verbal praises, or toys.

. VOICE CONTROL: The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor’s voice.

I understand that with the use of local anesthetic for dental purposes, the possibility exists that the child may inadvertently bite their lip, tongue, cheek, causing injury to occur.

Initials: ___________        Date: ___________

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 made by anyone regarding dental treatment, which I have requested and authorized. I have read and clearly understood the consent form language, and by signing below I acknowledge this understanding and give my consent to the doctor to perform the above-indicated procedure(s). My doctor has encouraged me to ask questions. I have had the opportunity to ask questions and any and all of my questions have been answered to my satisfaction.

Signature: ___________________________________________        Date: ___________

Doctor: ______________________________________        Witness: ___________________________