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DENTAL TREATMENT CONSENT FORM

Please read and initial below and read and sign the section at the bottom of the form.

1. **Work to be done**
   I understand that I am having the following work done:
   Fillings_____Bridge_____Crown_____Extractions_____Impacted Teeth Removed_____
   Local Anesthesia_____Root Canals_____ X-Rays_____ Exam_____ Other_____ **INITIALS_____**
2. **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) **INITIALS_____**
3. **Changes In Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of 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 gave my permission to the dentist to make any/all changes and additions as necessary. **INITIALS_____**
4. **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 breaking. 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 fees. I have also been explained the alternatives for dentures/partials including implant supported dentures. I am also aware in order to warrantee any prosthesis I will participate in regular exams and cleanings as diagnosed by my dentist. If I do not follow through with the hygiene protocol, the warranty will automatically be voided. **INITIALS_____**
5. **Fillings**
   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 a side effect after a newly placed filling. I also understand that fillings can turn into Root Canal treatment during or after the procedure. That means extra treatment at additional cost might be needed. I also understand that sometimes I might need to extract tooth if decay is too far and/or I cannot afford to do Root Canal treatment.
   INITIALS_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____