INFORMED AND TREATMENT CONSENT

Patient Name:_____ **Birthdate:**_____

Guardian/Parent Signature: _____**Date:**_____

Please read and initial the items checked below.

==========

1. I understand that I am having the following work done: Fillings_____ Crowns_____ Extractions_____ Impacted teeth removal_____ General Anesthesia_____ Root Canals_____ Other_____

(Initials:_____)

2. **Drugs and Medications**
I understand that antibiotics and analgesics and other medications that in RARE instances can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting and/or anaphylactic shock (severe allergic reactions), or temporary or permanent injury to nerves and/or blood vessels from the injections. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

(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 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 _____and any others necessary for reasons in paragraph #3. 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 permanently. (Paresthesis) that can last for an indefinite period of time (days of months) or fractured jaw or loss or damage of an adjacent tooth and/or restorations. 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. **Crown, Bridges and Caps**
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 understand that my gums may recede after the completion of my crown restoration. I understand that poor eating habits, oral habits (smoking, fingernail biting, etc..) and poor oral hygiene will negatively affect how long my crown lasts. 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.

(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 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 and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend 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. 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 causing gum and bone infection or loss and it 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**