

Timothy Wilson, DDS
DENTAL TREATMENT CONSENT FORM

Please Read Carefully.

Name of Patient

WORK TO BE DONE

I understand that I am having the following work done.

Fillings ___ Bridges ___ Crowns ___ Extractions ___ General Anesthesia ___ Root Canal/Pulpotomy ___ Other ___

Initials _____

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.

Initials _____

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 _____

REMOVAL OF TEETH

Alternative to removal of teeth have been explained due to (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 infection, if present, and it may be necessary to have further treatment. I understand the risk 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 tissues (PARESTHESIA) that can last for an indefinite period of time (days or months) 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 _____

CROWNS, 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 crown/bridge/cap is 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.

Initials _____

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 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.

Initials _____

ENDODONTIC TREATMENT (ROOT CANAL)

I realize that 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 (apicoectomy).

Initials _____

PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and of extractions. I understand the undertaking any dental procedures may have a future adverse effect on my periodontal condition.

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 _____

Signature of Parent/Guardian if parent is a minor

Date _____