Patient Dental Treatment Consent Form

INSTRUCTIONS: PLEASE READ AND REVIEW INFORMATION PROVIDED IN THIS DOCUMENT. ASK QUESTIONS FOR ANY ITEMS YOU NEED FURTHER EXPLANATION ON. CHECK (√) EACH BOX AND INITIAL WHERE REQUESTED.

Examination, X-Rays & Diagnosis

☐ I understand that dental x-rays (radiographs) are a necessary part of the diagnosis process and consent to having any dental x-rays necessary. I understand that the examination and diagnosis process also oral cancer screening and perio char probing and I consent to this process. I understand that should treatment be diagnosed for me that I will be given the opportunity to ask questions. Also, any fees associated with any treatment will be discussed with me at that time.

Initials ________

Oral Hygiene and Periodontics

☐ I understand that the long term success of treatment and status of my oral condition depends strongly on my efforts to maintain proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits as recommended by my dental care provider.

Initials ________

☐ I understand that I have a serious condition, causing gum and bone inflammation and/or loss, that it can lead to the loss of my teeth and many other complications. The various treatment plan options have been explained to me, including gum therapy and/or surgery, and replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extractions.

Initials ________

Changes in Treatment Plan

☐ I understand that during treatment it may be necessary to change and/or add treatment 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 my dental care provider to make any/all changes to my treatment plan as necessary.

Initials ________

Drugs, Medications and Anesthesia

☐ I understand that antibiotics, analgesics, and other medications may cause diverse reactions, some of which are, but not limited to: redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, and cardiac arrest. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol and/or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medication and/or drugs until fully recovered from their effects. I understand that occasionally upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection.

Initials ________

Fillings – Restorative

☐ I have been advised of the need for fillings to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to the wear of the material. 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 crowns), which would necessitate a separate fee.

Initials ________

Endodontic Treatment (Root Canal Therapy)

☐ I realize that there is no guarantee that root canal therapy 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.e. extractions).

Initials ________

Extractions (Removal of Teeth)

☐ I authorize my dental care provider to remove teeth if necessary due to the possibility of treatment plan changes as outlined above. 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, and loss of feeling in my teeth, lips, tongue, and surrounding tissue which may last for an indefinite period of time (days or months). I understand that should I need further treatment by a specialist or even hospitalization, if complications should arise, the cost of such is my responsibility.

Initials ________

Crowns (Caps) and Bridges

☐ 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 at times during the preparation of a tooth for a crown or a bridge, pulp exposure may occur, necessitating root canal therapy. I understand that natural teeth, crowns, and bridges need to be kept clean by maintaining proper regular and oral hygiene and periodic cleanings and exams. Otherwise, decay (cavity) may develop underneath and/or around the margins of the restoration, leading to the need for further dental treatment.

Initials ________

Dentures, Complete or Partial

☐ I realize that full or partial dentures are artificial, constructed of acrylic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. I understand that any adjustments done within 3 months of the delivery of the appliance are included in the original treatment fee, and that any adjustments beyond that will be at an additional cost, dependent upon my qualifications on the Sliding Fee Scale, per visit, per appliance. In addition, I understand that most dentures and partials require relining approximately three to six months after initial placement. The cost for this procedure is not included in the initial treatment fee.

Initials ________

General Consent

☐ I understand that any insurance benefits quoted are not a guarantee of benefits, but rather an estimate based on the information provided to our office by your insurance carrier. I understand I will be financially responsible for any amount(s) not covered by my insurance carrier.

☐ I understand that this facility provides dental care services without discrimination based on race, religion, color, nationality, sex, sexual orientation, physical or mental disability, and/or age, and protects the privacy of each of its individual patients.

☐ I certify that I have had the opportunity to read and fully understand the terms and conditions outlined within this document, and consent to cooperation and/or explanation referred to or made. I have been encouraged to ask questions and have had them answered to my satisfaction.

Initials _______

___________________________________ ____________________

PRINT PATIENT'S NAME DATE

___________________________________ ____________________

RESPONSIBLE PARTY'S SIGNATURE DATE

___________________________________ ____________________

WITNESS'S SIGNATURE DATE