DENTAL TREATMENT CONSENT

Patient Name:_____ **Date of Birth** (Month/Day/Year) _____

The dentist has reviewed my treatment plan and I understand that some or all of the following items may pertain to my care.

- **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). I will inform the dentist of any known allergies. I understand that local anesthetics may/will be used during my treatment.

- **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.

- **PERIODONTAL LOSS (TISSUE & BONE)**

I understand I have a serious condition causing gum and bone infection that can lead to the loss of my teeth. Treatment options have been explained to me, including scaling and root planning (deep cleaning) gum surgery, replacements and/or extractions. I understand much of the success of treatment depends on my continuing home care, following my dentist's recommendation and keeping scheduled appointments.

- **FILLINGS**

Fillings are used to replace missing tooth structure due to decay. I understand if there is additional decay, there may be additional treatment needed and possibly additional expense to the patient. I understand that sensitivity is a common after effect of a newly placed filling.

- **SEALANTS**

I understand that sealants are meant to help protect a tooth and help prevent decay on the chewing surface of a tooth. A sealant is not guaranteed protection from decay over time. The sealants may wear out and/or chip and may require periodic replacement. Depending on the age of the sealant replacement charges may be the patients' responsibility.

- **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 they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, kit, size and color) will be before cementation.

I understand that dentistry is not an exact science and 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 patient is a minor _____ Date _____

Witness signature _____ Date _____

DENTAL PROVIDER

I have informed the patient of the nature, purpose and possible consequences of the procedure, risk involved, possible complications and possible alternatives methods of treatment.

Dental Provider Signature _____ Date _____