DENTAL TREATMENT CONSENT FORM

Please be sure to read and initial the following items below, and sign at bottom of form. The following procedures may not apply to your needs. This consent is to inform the patient of the possible procedures that may apply and what could be the result of such procedures.

DENTIST'S NAME: Shana X. Crawford, DDS **Patient's Name: ______________________**

1. **EXAM/XRAYS/AND OR BASIC CLEANING. 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. **CHANGE 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 routing 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 Dentist to remove the following teeth if necessary. I understand removing teeth does not always remove all of the infection, and if present, it may be necessary to have further treatment. I understand the risks involved in having teeth removed, may include but are not limited to, pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissues (parathesis) 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: ______

5. **CROWNS, BRIDGES, AND CAPS:** I understand that sometimes it is 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 realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. I understand that after permanent cementation, it is possible that the crowns will come off or fracture due to design of the crown/trauma or accident/natural wear and tear/extreme occlusal forces/improper at home care, etc.
INITIALS: ______

6. **DENTURES, COMPLETE OR PARTIAL:** I realize that immediate, full, or partial dentures are artificial, constructed plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, and possible breakage. I understand wearing dentures is difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (placement of dentures after extractions) may be painful and understand that most dentures require relining approximately 3-12 months after the initial placement. In the case of immediate dentures, several relines and considerable adjusting may be required, as well as, a permanent reline. A new denture may need to be made due to the estimation of an immediate denture. I understand that the additional cost is my responsibility. I understand that the cost of any reline is not included in the initial denture fees. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be at the "teeth in wax" try-in visit. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. **INITIALS: ________**

7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my teeth, and that complications can occur from the treatment and that occasionally metal objects (files) are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that root canal teeth are susceptible to future fracture. I understand that occasionally the tooth may need to be re-treated for a root canal or additional surgical procedures may be necessary following root canal treatment (apicoectomy).
INITIALS: ______

8. **PERIODONTAL LOSS (TISSUE & BONE):**
I understand that serious gum problems (gingivitis) can lead to bone infection or bone loss and that it can lead to the loss of my teeth (periodontal disease). Alternative treatment may include scaling/root planing, gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition. **INITIALS: _______**

9. **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 expensive filling than initially diagnosed may be required due to additional decay (i.e. root canal treatment, crowns, extraction, etc.). I understand that significant sensitivity is common after effect of a newly placed filling. **INITIALS: _______**

I understand that dentistry is not an exact science, therefore, reputable practitioners can not 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 (Patient under age 18): ____________________________ **Date:** ________