DENTAL TREATMENT CONSENT FORM

DENTIST: Dr John Tchaboukian

PATIENT: _____

1. **X-RAYS** **(Initials_____)**
2. **DRUGS AND MEDICATIONS:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **(Initials_____)**
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of the 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. **FILLINGS**: I understand that care must be exercised in chewing on fillings especially during that first 24 hours after treatment is done to avoid breakage. I understand that the initial diagnosis may change and surfaces may be added due to additional decay once the Dentist starts treatment. I understand that significant sensitivity is a common after effect of a newly placed filling. **Tooth #**_____ **(Initials_____)**
5. **CROWNS, BRIDGE, AND/OR ONLAYS**: 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 a temporary crown(s). These temporary crowns may come off easily and I must be careful to ensure that they are kept on until the permanent crown(s) are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or onlay (shape, fit, size, color) will be before final cementation. **Tooth #**_____ **(Initials_____)**
6. **ENDODONTIC TREATMENT (ROOT CANAL)**: I understand there is no guarantee that root canal therapy will save my tooth and that complications can occur from treatment. I understand that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the additional surgical procedures that may be necessary following root canal treatment (apicoectomy) **Tooth #**_____ **(Initials_____)**
7. **REMOVAL OF TEETH**: Alternatives to removal have been explained to me (Root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the teeth diagnosed to remove. I understand that removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand that risks involved in having teeth removed, some of which pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (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. **Tooth #**_____ **(Initials_____)**
8. **PERIODONTAL LOSS (TISSUE & BONE) GINGIVECTOMY CROWN LEGENTHING**: I understand that serious gum treatment can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. **Tooth #**_____ **(Initials_____)**
9. **IMMEDIATE DENTURES**: I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require multiple adjustments/relines. A permanent reline will be needed later and the cost of reline is not included in the initial denture fee. I understand that it is my responsibility to return for the delivery of my dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. **(Initials_____)**
10. **DENTURES (COMPLETE OR PARTIAL)**: I realize that full or partial dentures are artificial, constructed of that plastic, metal, and/or porcelain. The problems of wearing these applications have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require reline approximately three to twelve months after initial placement and the cost of reline is not included in the denture fee, **(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/Parent/Guardian:_____ **Date:**_____

Signature of Treating Dentist: _____ **Date:**_____