
GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

- 1 **WORK TO BE DONE:** I understand that I am having the following work done [indicate all services being provided]: Fillings Bridges Crowns X-rays Extractions Removal of impacted teeth Root canals Dentures Other _____.
Patient initials _____
- 2 **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications may cause allergic reactions resulting in redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.
Patient initials _____
- 3 **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 discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
Patient initials _____
- 4 **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 following teeth:
_____ and any others necessary for reasons in paragraph 3. I understand that removing teeth does not always eliminate all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extraction, including pain; swelling; spread of infection; dry socket; loss of feeling in my teeth, lips, tongue and surround tissue (paresthesia) that can last for an indefinite period of time; and fractured jaw. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.
Patient initials _____
- 5 **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 make sure they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement, which may necessitate a remake of the crown, bridge or cap. In such instances, I understand that there will be additional charges for remakes because of my delaying permanent cementation.
Patient initials _____

6 **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Patient initials _____

7 **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss, and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition.

Patient initials _____

8 **FILLINGS:** I understand that care must be taken when chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required because of additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.

Patient initials _____

9 **DENTURES:** I understand that the wearing of dentures is difficult. Sore spots, altered speech and difficulty eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This procedure is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required because of my delay of 30 days or more, there may be additional charges assessed against me.

Patient Initials _____

I understand that dentistry is an inexact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) that I have requested and authorized.

I hereby authorize any of the doctors, dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of patient

Date

Signature of dentist

Date