

**Premier Family Dentistry Treatment Consent Form For:**

**1. EXAMINATIONS AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Initial \_\_\_\_\_

**2. DRUGS, MEDICATIONS, AND SEDATION**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initial \_\_\_\_\_

**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 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.

Initial \_\_\_\_\_

**4. LOCAL ANESTHETIC**

I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain; numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.

Initial \_\_\_\_\_

**5. FILLINGS**

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns

Initial \_\_\_\_\_

**6. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph #3. 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, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue, (Parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, cost of which is my responsibility.

Initial \_\_\_\_\_

**7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING**

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

Initial \_\_\_\_\_

**8. DENTURES- COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be in the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee.

Initial \_\_\_\_\_

**9. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment 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 (apicoectomy).

Initial \_\_\_\_\_

**10. PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand that undertaking any procedure may have future adverse effect on my periodontal condition.

Initial \_\_\_\_\_

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly 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 acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_