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Patient's Name   Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_______1. **TREATMENT:**
I understand I am having the following dental treatment performed:
o Fillings   o Crowns   o Bridges   o Dentures   o Extractions
o Impacted tooth removal   o Root Canals   o Other

_______2. **Drugs and Medications:**
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs. Female patients: Antibiotic medications can interfere with the effectiveness of oral contraceptives (birth control pills). You should maintain compliance with your oral contraceptives while taking the antibiotic but you should discuss with your physician the use of additional non-hormonal means of contraception to avoid possible unwanted pregnancy.

_______3. **Fillings:**
I understand that a more extensive restoration than originally planned 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.

_______4. **Crowns and Bridges:**
I voluntary consent to the crown or bridge which has been recommended to me. I have been informed that crowns that cover the tooth strengthen and help protect the tooth from fracture. I understand that a tooth can still break after being crowned. I also have been informed that bridges replace missing teeth. This is necessary in order to prevent or correct bite or gum problems which may occur when teeth shift position. Crowns and bridges are made of all porcelain or a combination of precious metals and porcelain.

Risks involved:
Preparation for the crown or bridge might reveal the need for a root canal procedure on the tooth.
After placement, the porcelain portion of the crown or bridge may crack and may require repair or replacement.
TMJ or temporomandibular joint dysfunction may occur if the crown or bridge changes the alignment of the teeth, which may require additional treatment.

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

I understand that the areas around crowns and bridges are harder to keep clean. I have further been informed that it is necessary to keep the areas free of food and other substances which can lead to decay and periodontal disease. I have been given instructions to follow to keep these areas clean and agree to follow the instructions carefully. I have further agreed to be treated by the dental hygienist 2 –4 times a year.

_______5. **Dentures:** I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less desirable result. If remake is required due to my delay, additional fees may be incurred.

_______6. **Extractions:** Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. It is my understanding that the following teeth will be removed:______________________ ____. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_______7. **Periodontal Disease:** Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and <u>may lead to loss of permanent teeth</u>. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_______8. **Root Canal Therapy:** I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not effect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not effect success. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise.

_______9. **Changes in Treatment Plan:**
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

_______10. **Alternative Treatment(s):**
Include: ____
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________11. **Temporomandibular Joint Dysfunction:**
I voluntarily consent to the treatment of temporomandibular joint dysfunction which has been recommended to me. I understand that the symptoms of TMJ are similar to other dental and systemic problems, and for that reason I have provided my dentist with a complete medical record. I have been informed that TMJ dysfunction can sometimes be treated simply over a short term or could require treatment over several years and could include orthodontic treatment, tooth restoration with crowns and bridges, or even surgery.

The procedure has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

Pain, bruising and swelling
Teeth, fillings and bridges could be damaged
Nerve damage causing temporary or permanent numbness of the chin, tongue, lips or face
Pain and spasms in the neck, ear, face, head and back
I fully understand that the treatment outlined may not successfully remove the problem and that the symptoms could worsen temporarily or permanently.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

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Patient’s (or Legal Guardian’s) Signature Date

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Doctor’s Signature Date

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Witness’ Signature Date