DISABILITY DENTAL SERVICES

DENTAL TREATMENT CONSENT FORM

Patient name_____

Please read and sign the section below for possible treatments at the clinic.

FILLINGS

I understand that the tooth/teeth will be filled with a composite or amalgam filling. I realize that filling a tooth is traumatic to the tooth, and the tooth/teeth may need a root canal later. I also understand that the tooth/teeth may be sensitive after treatment. The tooth/teeth may not be as strong as it was before, and may need a crown later.

CROWNS OR BRIDGES

I realize that working on a tooth is traumatic to the tooth, and the tooth/teeth may need a root canal later. I also understand that the tooth may be sensitive after treatment. The crown or bridge will not be exactly the same shape, size, or color as the original tooth/teeth, but will be as close as possible. Some conditions of the tooth/teeth may not be able to be totally corrected.

ENDODONTIC TREATMENT(ROOT CANAL)

I realize there is no guarantee that a root canal treatment will save the tooth/teeth. If complications do occur, I understand that an extraction may be necessary.

PERIO SCALING AND ROOT PLANING

I understand that periodontal disease is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth if not treated.

DENTURES OR PARTIALS

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing removable appliances have been explained to me, including looseness, soreness, and possible breakage. I understand most dentures require adjustment appointments for approximately three to twelve months after initial placement. The charge for these appointments is included in the denture fee.

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause nausea, vomiting, or other allergic reactions, including anaphylaxis.

CHANGES IN TREATMENT PLAN

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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. For example, root canal therapy following routine restorative procedures.

RESTRAINTS

I understand that prior to intravenous sedation, it may be necessary to use an oral pre-med, and/or physical restraint (arm restraint or lap belt), in order to protect the individual or others until the procedure is accomplished.

I have had the opportunity to read this form and ask questions. My questions were answered to my satisfaction; I consent to the proposed treatment.

_____ _____

Signature of Patient , Legal Guardian or Personal Representative Date

_____ _____

Signature of Witness for Patient Signature Date