WALNUT AVENUE dentistry

Dental Treatment Consent

Patient Name: ________________________________ Date of Birth: _______________________

1. **TREATMENT**: I understand that I am having the following work done:

   Fillings ___________ Crowns________ Bridges_________ Extractions___________ Anesthesia__________

   Periodontal & Cleanings_________ Digital X-Rays __________ Medicaments__________ (Initials)_______

2. **DRUGS & MEDICATION**: I understand that antibiotics and analgesics and other medications can cause allergic reactions, redness and swelling of tissues, 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 conditions found while working on the teeth that were not discovered in the initial examination. Most commonly may be root canal therapy if decay extends to the pulp of the tooth. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials) ________

4. **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 deemed necessary. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling on lips, tongue & surrounding tissue (parasthesia) 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 root canal treatment (apicoectomy). (Initials) ________

5. **CROWNS & BRIDGES**: I understand that sometimes it is very difficult to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing a temporary crown if the crown or bridge is not made the same day. I realize that I have the final opportunity to make changes to my new crown(s) or bridge (including fit, shape, size, color) before final cementation. (Initials) ________

6. **DENTURES;COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic or metal. The issues that arise from wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes to my new denture (including fit, shape, size, color) will be when the "teeth are set in wax" and in a try-in appointment. I understand that most dentures require approximately 3-12 months to feel comfortable after initial placement and will need denture adjustments and all adjustments are not included in the initial denture fee. (Initials) ________

7. **ENDODONTICS (ROOT CANALS)**: I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apicoectomy).

8. **PERIODONATL LOSS: (Tissue & Bone)** I understand that I have a serious condition, causing gum & bone infection & loss. This bone loss can lead to the loss my teeth if left untreated. Alternative treatment plans have been explained to me, including gum surgery, laser gum therapy, replacement and/or extractions. (Initials) _______

I understand that Dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask any questions regarding the dental treatment, and all questions have been answered to my satisfaction.

By signing below, you understand and agree to our **Dental Treatment Consent**. Thank you.

Patient Signature: ____________________ Print Name:_______________________________ Date:_____________

(Signature & Printed Name of Patient, Parent or Legal Guardian)