ANAHEIM Implant & Cosmetic DENTAL Group

# DENTAL TREATMENT CONSENT FORM

**Patient Name** _____

***Please READ and INITIALS the items checked below and read and sign the section at the bottom of form***

1. **WORK TO BE DONE**

**I understand that I am having the following work done:** ☐ Exam ☐ X-rays ☐ Prophy ☐ Sealants ☐ Fillings

☐ Crowns ☐ Bridges ☐ Extractions ☐ Impacted teeth Removal ☐ Root Planing ☐ Dentures ☐ Root Canal

☐ Others: _____

**(Initials)** _____

**2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing 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 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 permission to the Dentist to make any/all changes and additions as necessary.

**Changes:** _____ **Date:** _____ **(Initials)** _____

**4. REMOVAL OF TEETH** **Teeth:** _____ **Date:** _____

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 (Paresthesia) that can last for an indefinite period of time or fractured bone . I understand I may need further treatment by a specialist or even hospitalization if complications arise during of following treatment, the cost of which is my responsibility.

**(Initials)** _____

**5. FILLINGS –** ☐ **COMPOSITES** ☐ **AMALGAM** **Date:** _____

Amalgam "silver" fillings are utilized primarily for restoring posterior teeth. Composite or "tooth colored" fillings are primarily used when restoring anterior teeth. I understand that the dentist will determine the most appropriate material for restoring the tooth. I may request the restoration material of my choice for personal, cosmetic and/or health reasons, etc. I will be responsible for payment of treatment that is not a covered benefit of my insurance.

**(Initials)** _____

**6.** ☐ **CROWN** ☐ **BRIDGES** ☐ **VENEERS** **Date:** _____

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

**(Initials)** _____

**7. DENTURES –** ☐ **COMPLETE** ☐ **PARTIAL** ☐ **LAB. RELINE** ⬆⬇ **Date:** _____

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

**(Initials)** _____

**8. ENDODONTIC TREATMENT (ROOT CANAL) (RETREAT RCT) Teeth #** _____ **Date:** _____

I realize that 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)

**(Initials)** _____

**9. PERIODONTAL TREATMENT (TISSUE & BONE) SRP** ☐ **Date:** _____

I understand that I have a serious condition, causing gum inflammation or bone loss and that it can 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 undertaking any dental procedures may have a future adverse effect on my periodontal condition.

**(Initials)** _____

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***I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.***

**Signature of Patient or Parent or/Guardian if minor** _____ **Date** _____

**Signature of Attending Dentist** _____ **Date** _____ **Witness** _____