OPEN & AFFORDABLE
DENTAL BRACES

BP:_____/_____HR:_____BPM

CONSENT FOR DENTAL TREATMENT

Patient's Name: _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.
You have the right to be informed about your diagnosis and planned procedure so that you can decide whether to have a procedure or not after knowing the risks, benefits and alternative options.

Your diagnosis is: ☐ Caries ☐ Broken Tooth ☐ Root Canalled Tooth ☐ Other _____

Your planned treatment is : ☐ Filling(s) ☐ Crown ☐ Other _____

Alternative treatment methods include: ☐ Fillings(s) ☐ None ☐ Other _____
I understand that good oral hygiene is essential to prevent decay and to assist in the successful treatment of dental conditions.

_____ 1. **Drugs and Medications:**
I understand that antibiotics, pain medications, 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 told the doctor of any known allergies. I know it is important to take any medicines that are prescribed for me as directed to help minimize potential problems. Certain medications may cause drowsiness and I should not drive or operate hazardous equipment when using such drugs. If I have a problem, I should get appropriate medical care from either my doctor or in emergencies by calling 911.

_____ 2. **Fillings:**
I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I also understand that my tooth may not be salvageable and I may need other treatment options including a root canal or extraction. I understand that major changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____ 3. **Crowns and Bridges:**
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 re-cementing. I will notify my doctor if that happens so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes in the color, shape, size, etc. of a crown I may want must be made prior to final fabrication of the restoration. It is my responsibility to return for tooth preparation and final cementation of the restoration as directed by my doctor. If the crown or bridge becomes dislodged at any time, I need to call the doctor. I understand I may need further treatment by a specialist if complications arise during treatment, and I am responsible for paying any of those costs.

_____ 4. **Full and Partial 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. A natural process of resorption of the bone occurs making it necessary to have an annual checkup. If unsatisfactory stabilization of the dentures occurs, other options including dental implants may be needed to assist in stabilization. If it is necessary to remake the denture because I did not return in the time needed, there may be additional costs. Lab case return times vary by case. Because the office incurs significant laboratory fees, and staff and doctor time, upon agreeing to the treatment plan and the denture esthetic try-in, I am responsible for the full denture treatment plan price.

_____ 5. **Changes in Treatment Plan:**
I understand that it may be necessary during treatment to change or add procedures because of conditions discovered during treatment that were not evident during examination. If so, I will be advised by my doctor.
I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to have the recommended treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____