DENTAL TREATMENT CONSENT FORM

Patient name__________________________________ Birth date ______________________

Please read and initial the items chocked below. The read and sign the section at the bottom of the form.

1. WORK TO BE DONE

I understand that I am having the following work done: Filings___ Bridges___ Crowns___ Extractions ___________Impacted teeth removed _________ General anesthesia ________ Root canals ________Other_________

(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 procedure because 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 my permission Dr.Smiles Dental Boutique 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 Dr.Smiles dental Boutique to remove the following teeth _____________________ and any other necessary procedures in paragraph No. 3. I understand removing teeth does not always remove all 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, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paraesthesia) that can last for indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization, the cost of which is my responsibility.

(Initials ___________)

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5. Crown, bridges and caps

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept 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 ___________)

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing the 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 "tooth in wax" try-in. I understand the most dentures require refining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials ___________)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize 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 extended through the root, which does not necessarily affect success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy).

(Initials ________)

8. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that, I have a serious condition, causing gum and bone infection or loss. Alternative treatment plans have 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.

I understand that dentistry is not an exact science and that, therefore, dental practitioners cannot make a guarantee. I acknowledge that, no guarantee or assurance has been made to me by anyone regarding the dental treatment. I have had full opportunity to discuss and ask questions regarding the treatment and all questions have been answered to my satisfaction.

Patient_____________________________ Physician_______________________

If minor, Parent_____________________