Informed Consent to Treatment Form

What is an informed consent form? Your dentist wants you to understand the treatment you are considering. To do so you need to understand the risks associated with that treatment, as well as the benefits of the treatment. Your dentist also wants you to understand the alternatives available to you, from no treatment to other treatment options. Before treatments, please allow us to answer any questions you may have. By signing a consent to treatment form, you are indicating that you and your dentist have thoroughly discussed the risks, benefits, and alternatives for the treatment you will be given and that you have understood that discussion. Below are the possible risks associated with treatment and before each appointment the dentist and I will discuss all the risks, benefits, and alternatives for the procedure that day.

1. DRUGS, MEDICATIONS, AND SEDATION
I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that failure to take medication as prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to effective treatment or my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS)
I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. In cases involving PERIODONTICS or periodontal disease – I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high success rate, they cannot be guaranteed. Occasionally, treated teeth may still require extraction.

3. REMOVAL OF TEETH
Alternatives to removal have been explained to patient (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the removal of the teeth we discussed and agreed upon. 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 which include, but are not limited to the following: pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist, or even hospitalization, if complications arise during or following treatment, the cost of which is my responsibility.

4. FILLINGS
I have been advised of the need for fillings, to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crown), which would necessitate a separate charge.

5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)
I realize 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 treatment.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort, which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instrument during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the root canal material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.

If an “open and medicate” procedure is performed, I understand that this is not a permanent treatment, and I need to finish the final root canal therapy. If root canal treatment is not finalized I expose myself to infection and or tooth loss. If failure of root canal therapy occurs, re-treatment, surgical treatment or extraction may be needed.

6. CROWN AND BRIDGE (CAPS)
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, increased pulp sensitivity or pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crowns and bridges need to be kept clean with proper oral hygiene and periodic cleaning, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

7. DENTURES-COMPLETE OR PARTIAL
I realized that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage. I realized that the final opportunity to make changes in my new denture (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 placement. The cost for this procedure is not included in the initial denture fee. I further understand that surgical intervention (i.e. tori [bone] removal, bone contouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

8. 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 during examination, the most common being root canal therapy following restorative procedures. I know that the dentists will inform me at the time of unforeseen changes. I give my permission to the Dentist to make any/all changes and additions as necessary.

I UNDERSTAND THAT NO GUARENETTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF THE SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS. 

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION BEFORE I COMMENCE TREATMENT.

Financial Terms and Conditions

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of examination.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist the benefits accruing to me under my policy.

Doctor: ____________________________ Witness: ____________________________