CONSENT FORM
PROPOSED TREATMENT

☐ **1. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Initials** _____

☐ **2. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because conditions were found while working on the teeth that were not discovered during examination, the most common being endodontic treatment. I also understand that any/all changes will be added to my treatment plan as necessary. **Initials** _____

☐ **3. LOCAL ANESTHESIA**

The administration of any anesthesia involves certain risks including but not limited to: nausea, vomiting, pain, swelling/inflammation, allergic and/or unexpected reactions. If severe allergic reaction occurs, this can lead to more serious respiratory (lung) or cardiovascular (heart) problems, which may require treatment. In addition, there may be other risks which may include infection in the area of injection, injury to nerves or blood vessels in the area, disorientation confusion, and/or or prolonged drowsiness. I understand the risks of administrating anesthesia. **Initials** _____

☐ **4. COMPOSITE RESTORATIONS (FILLINGS)**

Composite fillings (white filling) are used to restore teeth from decay. I understand that the teeth treated may remain sensitive or even possibly quite painful both during and after completion of treatment. Regardless of which material is utilized I understand the risks which may occur even though care and diligence will be exercised in rendering this treatment. These risks include the possibility of unsuccessful results and/or failure which may need further treatment such as root canal therapy, extraction, etc. I also understand that restorations may break/fracture and/or change color. This can be due to many factors which the Dentist has no control over. **Initials** _____

☐ **5. PULP CAP #_____**

Sometimes after getting all the decay out there is a spot where the nerve has been reached, which will normally bleed a little. This is called "an exposure". The text-book thing to do is a root canal, but if the exposure is small and the bleeding is slight, the dentist will opt to do a pulp cap. This is used when the nerve is irritated but still alive and healthy enough to repair itself given a reasonable chance. The pulp-cap gives it a chance by getting rid of the decay and the bacteria and by creating a clean dressing over it with the filling. I understand that a pulp cap is a preventive method used to try to avoid endodontic therapy but is not guaranteed. **Initials** _____

☐ **6. ENDODONTIC TREATMENT (ROOT CANAL) #_____**

I realize that there is no guarantee that endodontic therapy will save my tooth. I understand that there are risks and complications involved during root canal treatment. Some of the risks and complication of treatment are, but not limited to, pain, swelling, breakage of instrument inside canal, extension of instrument through the root, etc. I understand that additional surgical procedures may be necessary following the root canal treatment. **Initials** _____

☐ **7. EXTRACTIONS #_____**

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.). I authorize the treating Dentist to remove the following teeth for the necessary for reasons. I understand removing teeth does not always remove all the infection, if any, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, bruising, spread of infection, dry socket, jaw fracture, and/or numbness of the lips, tongue, floor of the mouth, cheeks and/or surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

Initials _____

I understand that dentistry is not an exact science and therefore 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 agree to follow any preoperative and postoperative instructions given to me. I understand that it is my responsibility to contact the Dentist and seek attention should any circumstances occur postoperatively. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and consent to the proposed treatment.

_____

Name of Patient/Responsible Party

_____ _____

Signature of Patient/Responsible Party Date