# 21 DENTAL GROUP

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**Date:** .....

## TREATMENT CONSENT

1. **WORK TO BE DONE**
   I **understand** that I am having the following work done:
   Dental exam, X-rays, Dental cleaning, Fillings and Other dental care.
   **Initials** ( )
2. **DRUGS AND MEDICATIONS**
   I **understand** that antibiotics, analgesics and other medications can produce allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
   **Initials** ( )
3. **CHANGES IN TREATMENT PLANS**
   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 the examination, the most common being root canal therapy, following routine restorative procedures. I give my permission to my assigned dentist to make any and all changes/additions as necessary.
   **Initials** ( )
4. **CROWNS, BRIDGES AND VENEERS**
   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 realized that the final opportunity to make changes in my new crown, bridges or cap (including shape, fit, size and color), will be BEFORE cementation.
   **Initials** ( )
5. **DENTURES – COMPLETE OR PARTIAL**
   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 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 the initial placement. The cost for this procedure is not included in the initial denture fee.
   **Initials** ( )
6. **PERIODONTAL LOSS (TISSUE AND BONE)**
   I **understand** that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and or extraction. I **understand** that not undertaking any dental procedure may have an adverse effect on my future periodontal condition.
   **Initials** ( )

I **understand** that dentistry is not an exact science and that therefore reputable practitioners cannot properly 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 **understand** that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also **understand** that no other Dentist other than the treating Dentist is responsible for my dental treatment.

Authorized signature of covered person (For minor, Parent or Guardian)

Date .....