LOS ROBLES FAMILY & COSMETIC DENTAL CENTER
DENTAL TREATMENT CONSENT FORM

Patient Name:_____ **Date:**_____

Please READ and INITIALS the items checked below and 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:

☐ Fillings	☐ Extraction	☐ Root Canals	☐ Examination	☐ Night guard
☐ Bridges	☐ Impacted teeth	☐ Root Planning	☐ Prophylaxis	☐ Bleaching
☐ Crown(s)	☐ Dentures	☐ Sealants	☐ X-Rays	☐ Perio Maintenance

(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 procedures 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 permission to the Dentist 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 the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3.
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, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) of fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during the following treatment, the cost of which is my responsibility.

Teeth # _____ Date: _____ (Initials)_____

5. **BONE GRAFT**

I understand that when a tooth is extracted, the underlying bone tends to atrophy (shrink). Bone grafting is used to supplement bone on the area. Bone graft adds volume and density to your jaw where bone loss has occurred. I have been informed, and I understand the purpose of the bone graft procedure.

Teeth # _____ Date: _____ (Initials)_____

6. **FILLINGS COMPOSITE**

Composite or "tooth colored" fillings are used when restoring teeth. Amalgam Fillings are not used because they contain mercury. Some insurance will not cover composite fillings for posterior teeth. The patient will be responsible for the payment of the treatment that is not a covered benefit of the insurance.

Teeth # _____ Date: _____ (Initials) _____

7. **CROWN RESTORATIONS**

☐ Veneer Tooth # _____ ☐ Gingivectomy Tooth # _____

☐ Bridge Tooth # _____ ☐ Crown/Lengthening Tooth # _____

☐ Crown(s) Tooth # _____

☐ Bruxzir Crown Tooth # _____ (Optional)

Bruxzir crown is solid zirconia the strongest ceramic material.
They are not prone to chipping.
The Crown is more compatible with the tooth.

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I will 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** 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) _____

8. **DENTURES COMPLETE** PARTIAL

☐ Upper ☐ Upper
☐ Lower ☐ Lower

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 dentures (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.

(Initials) _____

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

Teeth # _____ Date: _____ (Initials) _____

10. **PERIODONTAL TREATMENT (TISSUE & BONE)** SRP ☐ UL ☐ LL ☐ UR ☐ LR

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, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials) _____

I understand that dentistry is not an exact science and that, therefore, reputable 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient or Parent / Guardian: _____ Date: _____

Signature of Attending Dentist: _____ Date: _____

Witness: _____ Date: _____