

# DC Dental Group

## CONSENT TO TREATMENT

TREATMENT TO BE DONE – I understand and consent to have any treatment done by the Dentist after the procedure, the risks, the benefits and the costs have been fully explained. These treatments include, but are not limited to x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, and/or dentures. Initial \_\_\_\_\_

DRUGS AND MEDICATION – I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Initial \_\_\_\_\_

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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. Initial \_\_\_\_\_

REMOVAL OF TEETH – I understand that there are alternatives to tooth removal (root canal therapy, crowns, and periodontal surgery, etc.) and agree to completely understand these alternatives, including their risks and benefits prior to authorizing the Dentist to remove teeth and any others necessary for reasons as above. 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 that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. Initial \_\_\_\_\_

CROWNS (CAPS) AND BRIDGES – Preparing a tooth may irritate the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold or pressure. Treating such irritation may involve using special toothpastes or mouth rinses or root canal therapy. 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. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation, and I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before permanent cementation. Initial \_\_\_\_\_

ENDODONTIC TREATMENT (ROOT CANAL) – I understand that there is no guarantee that root canal treatment will save a tooth, and that complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses occurring in their manufacture and calcifications present in teeth can cause them to break during use. I understand that referral to an endodontist for additional endodontic treatments may be necessary following any root canal treatment, and I agree that I am responsible for any additional costs for treatment performed by the endodontist. I understand that a tooth may require extraction in spite of all efforts to save it. Initial \_\_\_\_\_

PERIODONTAL DISEASE – I understand that periodontal disease is a serious condition causing gum and bone inflammation and/or loss and that it can lead to the loss of my teeth. I understand the alternative treatment plans to correct periodontal disease, including gum surgery, tooth extractions with or without replacement. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initial \_\_\_\_\_

FILLINGS – I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling or a crown may be required, as additional decay or fractures may become evident after-initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newly placed filling. I further understand that filling a tooth may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy.

Initial \_\_\_\_\_

DENTURES – I understand that wearing of denture can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. A permanent reline will be needed later, which is not included in the denture fee. I understand that all adjustments are included in the denture fee for a period of six months from the date of delivery, and that any and all adjustments or alterations of any kind and after this initial period are subject to charges.

Initial \_\_\_\_\_

I understand that dentistry is not an exact science and that no dentist can properly guarantee results.

I hereby authorize any of the dentists or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage (except covered AHCCCS fees) I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fee, collection fee, or court costs that may be incurred to satisfy any obligation to this office.

Date \_\_\_\_\_

\_\_\_\_\_  
Patient or Parent/Guardian Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Doctor Signature