

Consent for Dental Treatment

I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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, additional fillings from decay which was not visible on x-rays. 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.

RESTORATIVE DENTISTRY – CROWNS, BRIDGES, VENEERS, OPERATIVE (Fillings)

I understand, that unlike most other tissues in the human body, teeth do not have the ability to regenerate, thus any time a tooth is touched for any type of restoration, regardless of the size or the circumstance, there is always a risk of possible sensitivity, the need for a Root Canal, or even extraction.. This may occur even if the tooth was not sensitive prior to any treatment! I may experience sensitivity when chewing, eating or drinking anything hot or cold. The tooth may even be sensitive without apparent cause. The bite may need adjustment, or the nerve may be so severely traumatized that root canal therapy or even extraction may be necessary. Any loss of tooth structure may necessitate the need of a crown, or a root canal, or even extraction in the future. I understand that I will be financially responsible for any additional treatment which may be required if any of the aforementioned complications arise; such as having a root canal, extraction, or having treatment continued with a specialist.

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 come off easily, and that I must be careful to ensure that they are kept on until the final crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for definitive cementation within 30 days from tooth impression. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying final cementation. I understand that porcelain/ceramic, and filling materials may fracture and that I will be responsible to pay for replacement.

I understand that I am responsible for ALL Dental Laboratory Fees associated with, but not limited to: Crown/Bridge/Veneers/Temporaries/ Wax-Up (work that I may require an outside laboratory to fabricate for me)

I understand that NO Dental Restoration or Dental Prosthesis is permanent; most restorations need to eventually be replaced or re-restored sometime in the future. This need to *re-do* work is influenced by my oral habits, diet, oral hygiene, and maintaining regular bi-annual office visits for routine x-rays, and cleanings.

I understand that care must be exercised in chewing on filled teeth, especially during the first 24 hours to avoid stress. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that significant sensitivity is a common after-effect of a newly placed filling.

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

I realize that it is mandatory that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

I consent that photographs may be taken of me, under the following conditions:

1. The photographs may be taken only with the consent of my dentist and under such conditions and at such times as may be approved by him.
2. The photographs may be taken by my dentist or by a photographer approved by my dentist.
3. The photographs shall be used for dental records and if in the judgment of my dentist, dental research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he may deem proper in the interest of dental education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
4. The aforementioned photographs may be modified or retouched in any way that my dentist, at his discretion, may consider desirable.

Once consent is read, signature will be required electronically at office.