

Littleton Dental

DENTAL TREATMENT CONSENT FORM

1. WORK TO BE DONE

I understand that I am to have work done as detailed in the attached plan.

Initials_____

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, and vomiting, and/or anaphylactic (severe allergic reaction). I have informed the dentist of any known allergies to medication.

Initials_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedure 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; as long as I am informed.

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 infections, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parathesia) that can last for indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise, that cost of which is my responsibility.

Removal of the tooth leaves a socket that may not heal properly to allow the placement of the implant or proper restoration. A graft allows the socket to heal with the intention of preserving the bone for optimum results.

Other Oral Surgery Procedures:

I agree to additional oral surgery, which includes procedures such as alveoplasties, alveolectomy (bone re-contouring), root amputation apicoectomies, biopsies. I understand the risks involved, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment with a specialist if complications arise, the cost of which is my responsibility.

Initials_____

5. CROWNS AND VENEERS

a. Treatment involves covering the tooth above the gum line with a cap (crown) or covering the front surface of the tooth colored bonded porcelain laminate called a veneer. 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

permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementations.

It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. Boulder Dental Center does not endorse the use of base metal in crowns and is not responsible for any untold or allergic reaction to the metal or cost incurred for additional treatment needed to correct problems associated with base metal crowns.

Initials_____

b. I am electing to follow Boulder Dental Center's recommendation of using noble metal instead of base metal in my crown and bridge restoration.

Initials_____

c. I am electing to do a fixed bridge replacement of missing teeth instead of a removal appliance. I understand that this fixed bridgework may not be covered benefit under my insurance policy.

Initials_____

6. INLAYS/ONLAYS

I understand a more extensive restoration may be required due to additional decay found during preparation. Due to the size of the preparation or due to the size of the present restoration the tooth will not support a filling. I understand a tooth restored with inlay or onlay is more conservative than doing a crown at this time. I understand that sensitivity is common after initial cementation.

Initials_____

7. FILLINGS

I understand a more extensive restoration than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that sensitivity is a common after-effect of a newly placed filling. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____ Tooth colored resin for this/these tooth # _____

An amalgam restoration requires the Dentist to remove a larger amount of tooth structure when preparing the tooth for restoration. Amalgam fillings are dark in color. In contrast, the resin restoration bonds to the tooth and can actually strengthen the tooth structure/ It also matches the color of the tooth and is virtually undetectable to the untrained eye. Because it is more technique sensitive, placement of a resin filling may take longer than an amalgam and thus is more expensive. Insurance patients please note: your insurance company may not pay for resin restoration at all or it may reduce your benefit to that of an amalgam filling, especially when the restoration is on a posterior (molar or bicuspid) tooth. Please carefully review our consent form and discuss any questions with your dental provider.

Initials_____

8. 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 the canal filling material may extend through the tooth root tip, which does not necessarily affect the success or the treatment. The tooth may be sensitive during treatment and

even remain tender for some time after treatment. Hard to detect root fractures is one of the main reasons why root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. It also prevents a root canal from being re-infected. I understand that endodontic files and reamers are very fine instruments and stresses in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Initials_____

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that the tooth may be lost in spite of all efforts to save it.

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same, better or worse after treatment and that ongoing care may be necessary.

Initials_____

10. DENTURES, COMPLETE OR PARTIAL

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months.

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problem 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. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charged.

Initials_____

11. BLEACHING

Bleaching is a procedure done either in office (1 hour) or with take home trays (2 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on dental shade guide). Coffee, tea, and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The doctor may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are

approved by the FDA as mouth antiseptics. Their use as beaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician.

Initials_____

12. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand possible side effects that might occur.

Initials_____

13. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I elect to follow the doctor's recommendations of optimal dental treatment, including all comprehensive procedures.

Initials_____

I understand that dentistry is not an exact or fully predictable science and that reputable practitioners cannot properly guarantee results. I acknowledge no guarantee or assurance has been made by anyone regarding 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 proposed treatment.

14. RELEASE FROM LIABILITY AGAINST DOCTOR'S ADVISE

Being a lawful age, I hereby release Dr. _____ of Littleton Dental, its associate, employees and agents from all liability for any injury I currently, or may in the future, suffer as a result of my refusal to have the following service (s) or consultation (s) performed:

- ____ Exam
- ____ Radiographs
- ____ Referral / treatment for periodontal condition
- ____ Other _____

I have thoroughly discussed the need for service (s) or consultation (s) with the Doctor. All of my questions have been answered and I fully understand why the recommendation has been made and the consequences of my refusal to have them performed. I also understand that in the even of an emergency, i.e. pain, swelling, the office will do its best to accommodate me, and I will be charged a fee for a limited emergency exam in addition to the cost of treatment each time this occurs.

Signature of Patient/Parent/Guardian

Date