Woodholme Smile Care - Dental Treatment Consent Form

Please read and initial the items checked below and read and sign at the bottom of form

1. Medications & Anesthetics (Initials)

I understand that antibiotics and anesthetics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

2. 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, the most common being root canal therapy following routine restorative procedures.

3. Removal of Teeth

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 (Parethesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

4. Crowns & Bridges

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 realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

5. 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 involved restorative treatment may become immediately necessary, should it be determined that there is not adequate natural tooth structure remaining to support a tooth colored bonded filling. Additionally, larger more extensive fillings may eventually need additional treatment including, but not limited to, root canal therapy +/or crown. I understand that significant sensitivity is a common, short-term, after effect of a newly placed bonded tooth-colored restoration.

6. Dentures 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 dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining or remaking approximately three (3) to twelve (12) months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline or remake will be needed later. This is not included in the denture fee. 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 fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

7. Tissue & Bone Loss

I understand that serious gum problems can lead to irreversible bone infection +/or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, bone grafting, replacements and/or extractions. I understand that undertaking any dental procedures may have a future effect on my periodontal condition.

8. Root Canal Therapy

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 files 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).

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. 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, nor Woodholme Smile Care, is responsible for my dental treatment. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. Treatment benefits, possible complications and alternatives have been thoroughly explained to me by my doctor. 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 Responsible Party (for minors)