MAMKIN
DENTISTRY
aesthetic & restorative center

DENTAL TREATMENT CONSENT FORM

Patient's Name:_____ DOB_____

I hereby authorize and direct the dentist(s) of Dental Care of Ridgewood, PC to perform the following dental treatment(s), including the use of any necessary or advisable local anesthesia, radiography (X-rays), or diagnostic aids. Please read and sign the items below.

1. DRUGS AND MEDICATIONS

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 (severe allergic reaction).

(Signature_____)

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. I give my permission to the dentist to make any/all changes and additions as necessary.

(Signature_____)

3. 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 expensive filling than initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common aftereffect of a newly placed filing.

(Signature_____)

4. ENDODONTIC TREATMENT (ROOT CANAL)

I realize that there is no guarantee that root canal treatment will save my tooth. Many factors affect the success of the treatment: a patient's general health, condition of the nerve and the root canal(s), bone support around the tooth, and the strength of the tooth. Root canals are sometimes completed in a single appointment or may take several appointments. If the treatment spans several appointments, I understand that I will have a temporary filling placed on the tooth to protect the canal.

Once treatment is begun, it is absolutely necessary that the treatment be completed, and the patient must diligently follow any and all instructions. I understand that there are various inherent or potential risks that can occur as a result of said procedure(s) despite all efforts to the contrary, which include but are not limited to: pain, swelling, bleeding, sensitivity, infection and/or bruising which may require additional treatment. Changes in occlusion (biting), jaw muscle cramps and/or damage to existing restoration may require replacement, and further treatment. Involvement of the nerve within the lower jaw resulting in temporary (but possibly permanent) tingling and/or numbness in the lip, chin, tongue, gums, cheeks and teeth. Complications may arise, resulting from the use of dental instruments (broken instrument, perforation of tooth, root and/or sinus), discoloration and or swelling of the face. Occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Signature_____)

5. CROWNS, BRIDGES AND CAPS

In order to replace decayed or otherwise traumatized teeth, it is necessary to modify the existing tooth or teeth so that crowns (caps) and/or bridges may be placed upon them. The tooth or teeth may have been traumatized from an accident, deep decay, extensive preparation, extensive operative history or other unknown causes. It is often necessary to do root canal treatments on these teeth prior to the placement of crown/bridge. Crowns and bridges may possibly chip or break. Many factors could contribute to this outcome such as chewing excessively hard materials, changes in biting forces, trauma to the mouth, etc. Unobservable cracks may develop in crowns from these causes, but the crowns/bridges may not actually break until chewing soft foods or possibly for no apparent reason. Breakage or chipping seldom occurs due to defective materials or construction unless it occurs soon after placement. 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.

(Signature_____)

6. DENTURES: COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems associated with wearing these appliances have been explained to me, and I understand that wearing dentures is difficult. Sore spots, possible breakage, altered speech, and difficulty 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 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, and 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. I realize that 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.

(Signature_____)

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

Signature of Parent/Guardian if Patient is a Minor_____ Date_____