Just Dental
General for Adults & Children

INFORMED CONSENT FOR DENTAL TREATMENTS

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

- **1. Work to Be Done**
  I understand that I am having the following work(s) done:
  _____________ Fillings _____________ Bridges _____________ Crowns _____________ Extractions
  _____________ General Anesthesia _____________ Root Canals _____________ Cleanings

  (Initials _____________)

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

  (Initials _____________)

- **3. Changes in Treatment Plan**
  I understand that it may be necessary to change or add procedures during treatment due to conditions found while working on your 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.

  (Initials _____________)

- **4. Dental Prophylaxis (Cleaning)**
  I understand that thorough cleaning of teeth is necessary to help heal inflamed or infected gum tissue. The procedure involves the removal of soft plaque build-up and harder calculus deposits above and below the gum line. *Fluoride* is highly recommended as a part of the cleaning procedure. It is, however, my responsibility to let dental staff know if I wish to not have fluoride applied.

  (Initials _____________)

- **5. X-Rays**
  At Just Dental, digital imaging uses less radiation, which means very little radiation is used and it is extremely safe. I understand that radiographs–intraoral (inside the mouth) may be required to complete the examination, diagnosis, and treatment plan.

  (Initials _____________)

- **6. Fillings**
  I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during tooth preparation. That is if my tooth/teeth do not respond to the filling treatment, then further treatment such as a root canal therapy or crown may be necessary. I understand that significant changes in response to temperature may occur after tooth restoration, such as temporary sensitivity or pain. I understand that fillings are not permanent and require periodic replacement. I fully understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

  (Initials _____________)

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- **7. Extraction - Removal of Teeth**
  Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, ect.) I authorize the Dentist to remove the following ***teeth*** ___________________ *a*nd 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 infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during the following treatment, the cost of which is my responsibility.

  (Initials _____________)

- **8. Crowns, Bridges, and Caps**
  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.

  (Initials _____________)

- **9. Dentures (Complete 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 denture (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.

  (Initials _____________)

- **10. Endodontic Treatment (Root Canals)**
  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 objects 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).

  (Initials _____________)

- **11. Periodontal Loss (Tissue and Bone)**
  I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

  (Initials _____________)

Patient Signature: ____ Date: ____________________

Patient Name: ____

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