ULTIMATE DENTAL CARE
DENTAL TREATMENT CONSENT FORM

1. WORK TO BE DONE

I understand that I am to have work done as detailed in the attached treatment 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 shock (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.

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 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 by 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 with a 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 insure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make any changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive days may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation. Ultimate Dental Care does not endorse the use of base metal in crowns and is not responsible for any untoward or allergic reactions to the metal nor cost incurred for additional treatment needed to correct problems associated with base metal crowns.

   Initials _____

b. I am electing to follow Ultimate Dental recommendation of using high noble instead of base noble in my crown and bridge restorations.

   Initials _____

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

   Initials _____

6. 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 of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fractures are 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 reinfected. 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 _____

7. 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 periodontal disease may have a future adverse effect on the long-term success of dental restorative work.

Initials _____

8. FILLINGS

I understand that 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 effect after a newly placed filling.

Initials _____

9. DENTURES, COMPLETE OR PARTIAL

I realized that full or partials 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 any 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 appointment may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

Initials _____

10. 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 bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials _____

11. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand possible side effects that may occur. These include, but are not limited to nausea, vomiting, dizziness, and headache. I also understand that nitrous oxide use is not recommended if I am pregnant.

Initials _____

12. DENTAL BENEFITS

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

Initials _____

I understand that dentistry is not an exact 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.

_____ _____

Signature of Patient/ Parent/ Guardian Date

_____

Printed Name