Gomes Dentistry
General Dentistry for Adults & Children

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Dental Treatment Consent Form

Patient's Name_____

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

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

TREATMENT TO BE PROVIDED

I understand that during my course of treatment that the following care may be provided: Examinations, Preventative Services, Restorations, Crowns, Bridges, and Dentures.
I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **(Initials_____)**

1. 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. **(Initials_____)**

2. X-RAYS (Initials_____)

3. 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, and/or anaphylactic shock (severe allergic reaction). **(Initials _____)**

4. RESTORATIONS (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 that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. **(Initials_____)**

5. 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 #1. 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 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. **(Initials_____)**

6. 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. **(Initials_____)**

7. 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 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. 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 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 require due to my delays of more than 30 days there will be additional charges. **(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 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_____)**

9. PERIODONTAL TREATMENT (TISSUE & BONE)

I understand that no dental treatment is completely risk-free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include tooth sensitivity, pain from treatment, infection, swelling, dark spaces between teeth where there is no longer any gum tissue, and changes in how long my teeth appear (due to recontouring). I understand that as the health of my gum tissue improves, the tissues may shrink or recede: this is a normal reaction to treatment. This change may make some previous dental restorations (crown, fillings) more noticeable and they may need to be replaced to make them more cosmetically acceptable. I understand that I may be given a local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. **(Initials_____)**

I realize and acknowledge that there are risks and/or complications associated with dental procedures. I understand that should any of the risks occur during or as a result of my dental treatment, Dr. Gomes or Dr. Leung may refer me to a specialist or medical doctor for further treatment of my dental condition and/or any treatment required due to the associated risk. Some of the possible complications and/or risks may include, without limitation:

1. Allergic reactions from local anesthetics, medicated rinses, latex gloves, prescription medication, or other products used in the treatment of dental conditions.
2. Trauma to adjacent oral structure, such as teeth, gums, tongue, cheek lip or face.
3. Irreversible pulpitis, necessitating root canal therapy or extraction, due to extent or depth of decay and/or the amount of tooth structure prepared as prescribed for treatment of tooth.
4. Permanent or temporary numbness associated with the administration of local anesthetic, extraction of teeth, root canal therapy, infection, or other oral surgical procedures.
5. Pain or discomfort associated with the TMJ or jaw joint.
6. Elevated tooth sensitivity to hot, cold, sweets, pressure, air, and chewing or biting.
7. Aspirating (breathing in) or swallowing dental instruments, dental products or tooth structures.
8. Breakage of dental instruments such as root canal files, dental burs, dental hand instruments.
   (Initials_____)

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

Signature of Patient _____ Date_____

Signature of Parent/Guardian _____Date_____