Consent For Dental Treatment
Dr. Dan L. Stambaugh

Patient's Name _____ **Date** _____

PLEASE READ THIS INFORMATION REGARDING DENTAL TREATMENT, THEN SIGN ON THE NEXT PAGE. A COPY WILL BE PROVIDED FOR YOU.

1. **TREATMENT:**
   I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Impacted tooth removal, Root canals, implants, treatment of periodontal disease or other work necessary.

2. **DRUGS AND MEDICATIONS:**
   understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

3. **RISKS OF DENTAL ANESTHESIA:**
   I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

4. **FILLINGS:**
   I understand that a more extensive restoration than originally planned, or possibly root Canal therapy, may be required due to additional conditions discovered during preparations. I understand that significant changes in response to temperature may occur after tooth Restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

5. **CROWNS, BRIDGES, INLAYS, ONLAYS, AND IMPLANTS:**
   I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. Time frame may vary for implants. I understand I may need further treatment in this office or possibly by a specialist for implants or if complications arise during treatment. Any costs thus incurred are my responsibility.

6. **DENTURES:**
   I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as; shrinking bone and gums, poor chewing ability, altered speech, reduced tasted and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time and there is a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

7. EXTRACTIONS

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

8. ROOT CANAL THERAPY:

I realize root canal therapy has a very high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth non-restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infections where conventional root canal therapy is not enough and might need further surgery or treatment by a specialist at additional costs to me. a small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away, might lead to fracture of the tooth and possible extraction.

9. CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Witness' Signature Date