Kenosha Breeze Family Dental Treatment Consent Form

Patient Name:_____

DIAGNOSTIC AND PREVENTATIVE

I understand that I am having the following work done: Fillings, Cleaning, Scaling, and any other necessary preventative treatment.

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).

NITROUS OXIDE

I understand that nitrous oxide (laughing gas) provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history.

LOCAL ANESTHETIC

I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.

FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function including root canal, crown, or both. I understand that the composite filling can come out and will need to be replaced depending on the placement of the filling. I understand there may be some sensitivity associated with having a composite filling that can last for a day or weeks until the body gets adjusted to the new composite.

REMOVAL OF TEETH

Alternatives to removal have been explained to me and I authorize the dentist to remove any necessary teeth. I understand that removing teeth does not always remove all 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 that can last for an indefinite period of time (days/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.

CROWNS AND BRIDGES

I understand that sometimes it is not possible to match the color of natural teeth exactly to 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 or bridge will be before cementation.

DENTURE, 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 will be the "wax in teeth" 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.

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).

I have had the opportunity to read this form and ask questions. I consent to all proposed necessary treatment.

Signature of Patient or Legal Guardian _____ **Date** _____

Signature of Doctor _____ **Date** _____