

**Thomas M. Anderson DDS PA**

***INFORMED CONSENT FOR DENTAL TREATMENT***

**This document is intended to provide you with an overview of certain procedures and potential risks and complications. Your initials and signature below acknowledge that you have read and understand this document and consent to treatment.**

**Initials**

1. **X-RAYS-** I understand that x-ray films are needed for diagnosis of cavities, gum disease, oral pathology, and many other dental conditions. I **understand** that by declining x-rays the dentist is only doing 50% of an examination. I also understand that by declining x-rays any undiagnosed decay or other pathology found at a later date can lead to serious consequences such as tooth loss, root canals, and life threatening pathology.

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2. **DRUGS AND MEDICATIONS-** I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions causing redness and swelling of tissues, temporary or permanent numbness, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I also understand that medications that are prescribed from other physicians may cause harmful side effects such as dry mouth, which may cause damage to my teeth and gums.

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3. **EXAM AND CHANGES TO TREATMENT PLAN-** I understand that a limited or complete examination may be done based on my reason for visiting the dentist. I understand that during **treatment** it may be necessary to change or add procedures because of conditions found while working on my teeth that were not discovered or not visible during examination (for example-cracks, fractures, decay into pulp tissues). I give my permission to Dr. Anderson to make any/all changes and additions as necessary.

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4. **REMOVAL OF TEETH-** I acknowledge that alternatives to extraction(s) have been explained to me. Those options include (root canal, crowns, periodontal surgery, orthodontics, implants, fillings). I authorize the dentist to remove any teeth if extraction is the only option or my personal elective choice. I understand the risks involved in having teeth extracted. They include pain, swelling, spread of infection, sore TMJ muscles from opening my mouth, dry socket, loss of feeling in my lip, teeth or tongue and surrounding tissues (paresthesia), which can last for an indefinite period of time (days to months or longer). I understand that it takes several weeks to heal. I understand that tobacco products are absolutely not recommended during healing. I understand the risk of fracture to jaw bone and pieces of bone or tooth that may be present weeks, months or years after the extraction. I also understand that I might need further treatment, hospitalization and surgery by a specialist if complications should arise during or following treatment. An example would be an ankylosed root/tooth (fused to bone). The cost of any referrals to a specialist is my responsibility.

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5. **CROWNS (CAPS) AND BRIDGES-** I understand that sometimes it is not possible to match the exact color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns or bridges, which may come off easily. I must be careful to ensure they are kept on until the permanent crown or bridge is delivered. I understand that in some cases a gold crown may be the only choice to restore posterior teeth because porcelain needs to be much thicker than gold to be strong enough to withstand chewing and biting forces in this area. I understand that once my crown is cemented permanently I cannot go back and change the color, shape, fit or size. I understand that crowns and bridges are not as strong as natural teeth. I understand they can break, chip and still get decay underneath.

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6. **COMPLETE AND PARTIAL DENTURES-** I understand 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. The expectations of wearing these appliances have been explained to me. These include: looseness, soreness, ulcers, thick feeling, thin feeling, breakage, storage, changes in diet, changes in habits, biting my cheek, tongue or lip. I realize that dentures made prior to extractions (immediate dentures) have the most problems. I understand that they will require a relin after a few months of healing. I understand that bottom dentures do not have suction. I have been advised that replacing an old denture with a new one does not guarantee that it will fit better due to bone loss over time. I have been given a hand out from the dentist on what to expect with dentures/partials. I understand that it is my responsibility to return for the delivery of the denture within 30 days from the start or there is a risk that the denture/partial will not fit. I understand that dentures/partials are not the same as natural teeth.

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7. **PERIODONTAL LOSS (GUM TISSUES and BONE)-** I understand that not flossing, not brushing, not coming for regular check-ups, habits such as smoking, chewing tobacco, tongue rings, deep subgingival crowns and fillings, as well as genetics can cause gum disease (bone loss, bleeding, mobility). I understand that I might need to be referred to a specialist for treatment of my periodontal tissues. I understand that failure to see a specialist as per the dentist's recommendation can result in tooth, tissue and bone loss.

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8. **FILLINGS-** I understand that care must be exercised after a filling is placed. I understand that it takes 24 hours for the filling to set up. I understand that if the filling feels "big" or "high" that I should contact the dentist immediately or trauma could occur to the nerve tissues inside my tooth. I understand that a more expensive filling than what was originally proposed may be needed due to additional decay found during treatment. I understand that sensitivity after a

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filling is a normal side effect that may take weeks or months to calm down. I understand that when the decay is removed from my tooth, it can encroach upon the nerve tissues and result in sensitivity to cold, hot and possibly a root canal. I understand that the deeper the cavity, the more chance there is for my nerve to be involved and need a root canal. I understand that large fillings do not make my teeth stronger and further treatment may be needed such as a crown or root canal. I understand that not all cavities hurt or cause pain when detected early. I understand that if I do nothing to a cavity will eventually reach the nerve tissues and result in pain, infection and discomfort. I understand that when cavities are found, it is my responsibility to schedule to have them restored. I understand that failure to do so can and will result in potential root canals or extractions.

**I understand that dentistry is not an exact science and that no treatment can replace or replicate natural healthy teeth and gums, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no one, including Dr. Anderson, has made any guarantee or assurance regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask Dr. Anderson any questions, which have been answered to my satisfaction.**

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Patient's Signature:

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Print Name

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Date

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Parent Signature if Patient is a Minor

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Date