DENTAL PROCEDURE CONSENT FORM

ALPHA DENTAL
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Patient Name _____ Date of Treatment: _____/_____/_____
first last

Please read and initial the applicable items. Then sign below.

Initials	I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and consented for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.	Dr.Initials
Initials	1. WORK TO BE PERFORMED I understand that I am having the following work performed : (please circle) Fillings – Bridges–Crowns–Extractions–Impacted Teeth Removed - Local Anesthesia – Root Canals –Cleaning (general/deep) –X-Rays -Exam - Other: _____	Dr.Initials
Initials	2. 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).	Dr.Initials
Initials	3. CHANGES IN TREATMENT PLAN I understand that during treatments 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 such as Fillings, Crowns, Prosthetics etc. I give my consent/permission to the Dentist to make any/all changes and additions as necessary.	Dr.Initials
Initials	4. REMOVAL OF TEETH Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr. Saka to remove the following teeth _____ and any others necessary for reason in paragraph #3. I understand removing 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, etc. Additional risks are damage or loss of additional teeth, restorations, existing prosthetics such as crown and bridges etc. I understand I may need further treatment by a specialist of even hospitalization of complications arise during or following treatment, the cost of which is my responsibility.	Dr.Initials
Initials	5. CROWN, BRIDGES AND CAPS 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, bridges, or cap (including shape, fit and size) will be before cementation. Changes in color cannot be altered after the shade approval has been signed. I have been informed and understand the possibility that in preparing the restoration, the pulp (nerve) of the tooth (teeth) may become inflamed (pulpitis) and this condition may become irreversible. If this occurs I may experience sensitivity to hot and cold temperature, discomfort and pain when chewing, necrosis of the pulp resulting in abscess (infection) and destruction of supporting bone etc. Endodontic treatments that will incur additional cost.	Dr.Initials
Initials	6. DENTURES, COMPLETE OR PARTIAL I realize that full or partial dentures are artificial, constructed of acrylic, resin, 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 and placement) will be the “teeth in wax” try-in visit. Changes in color cannot be altered after the shade approval has been signed. 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.	Dr.Initials
Initials	7. 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 or re-treat). After endodontic treatments an abscess or swelling may occur resulting in additional necessary dental surgery.	Dr.Initials
Initials	8. PERIODONTAL LOSS (TISSUE & BONE) TREATMENT I understand that I have serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatments plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Bleeding, sensitivity and swelling are adverse reactions of periodontal treatment(s).	Dr.Initials

Patient Signature _____ Date _____/_____/_____

By typing in your name, you are signing this Agreement electronically. You agree your electronic signature ("E-Signature") is the legal equivalent of your manual/handwritten signature on this form. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature.

If Minor (Print name of Parent, Guardian, or Representative) _____