DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form

___1. WORK TO BE DONE
I understand that I am having the following work done: Fillings_____Bridges____Crowns_____Extractions____Root Canals_____Other_____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). Initials_____

___3. 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_____

___4. 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 #3. 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 in rare occasions may be permenant; or fractured jaw.

_____ _____
Patient Signature Date

_____ _____
Dentist Signature Date

_____ _____
Witness Signature Date