SOUTHERN INDIANA DENTAL CARE
Family Dentistry

Please read and sign the
Consent at the bottom of the form. Patient Name_____

1. DRUGS AND MEDICATION

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).

2. LOCAL ANESTHESIA

I understand the use of local anesthetic may cause paresthesia (altered sensation), swelling (hematoma), bruising, increased heart rate, possible allergic reactions, and/or abrasions.

3. CHANGES IN TREATMENT PLAN

I understand that during dental 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 permission to the dentist to make changes and additions.

4. 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 additional surgical procedures may be necessary following root canal treatment (apicoectomy).

5. EXTRACTION OF 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 tissues (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

6. CROWNS AND BRIDGES

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, bridge, or cap (including shape, fit, size, color) will be before cementation.

7. COMPLETE OR PARTIAL DENTURES

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 understand that most dentures require relining approximately three to twelve months after initial placement. The cost of the reline is not included in the initial denture fee.

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I may have a serious condition causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans are available in most cases including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that in dentistry reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask any question. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____Date_____

Signature of Parent/Guardian if patient is minor_____Date_____