Family Dental
Westborough

Dental Treatment Consent

1. I authorize dental treatment including local anesthesia, examination, radiographs (x-rays) or diagnostic aids.

2. In general terms, dental treatment may include but is not limited to one or a number of the following:
• Administration of local anesthesia
• Cleaning of the teeth and application of topical fluoride
• Scaling and root planing with local anesthesia
• Application of sealants to the grooves of the teeth
• Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
• Stainless steel crowns for children. These are necessary in cases where simple filling would not be the best long-term restoration or in cases where there are large cavities.
• The replacement of missing teeth with a dental prosthesis (crown, partials, etc)
• Treatment disease or injured oral tissues (hard/or soft)
• Treatment of malposed (crooked) teeth and/or development abnormalities.
• Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment)

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscles cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or modify all procedures because of conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges

I understand that sometimes it is not possible to match the color of the 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 in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____