**DENTAL TREATMENT CONSENT FORM**

Dr Paul Cashman c/o Canterbury Prosthetic Dentistry

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**1. EXAMINATIONS/CONSULTATIONS**

I understand that a full and comprehensive examination is required prior to treatment to identify the cause of the problems, to make a diagnosis and to put together a treatment plan to help correct any issues. Over time, it may be necessary redo the examination process to determine if issues have been addressed or if new issues arise. (Initials\_\_\_\_\_\_)(I

**2. RADIOGRAPHS AND SPECIAL TESTS**

I understand that during treatment it may be necessary carry out special investigations such as radiographs, vitality testing and diagnostic casts. I understand that further investigations may be required at different stages during treatment. (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, e.g. root canal therapy following restorative procedures. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

**4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorise the Dentist to carry out interventions as discussed and agreed upon. 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 fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

**5. CROWNS, BRIDGES AND RESTORATIONS**

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 for some time. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and colour) will be before cementation. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

**6. DENTURES, COMPLETE OR PARTIAL**

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 realize the best opportunity to make changes in my new dentures (including shape, fit, size, placement, and colour) will be the “teeth in wax” try-in visit. Further changes are possible but may incur further costs to me. I understand that dentures require relining at various intervals after initial placement. The cost for this procedure is not included in the initial denture fee. (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. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

**8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I must take responsibility for cleaning my teeth. If I have any questions about brushing, flossing or other aspect of keeping teeth clean, I will ask for further education and support. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

**9. FILLINGS**

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that sensitivity and tenderness is a possible after-effect of a newly placed filing. (Initials\_\_\_\_\_\_\_\_\_\_\_\_\_)

I understand that dentistry is not an exact science and that, therefore, 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 questions. 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 a minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_