Procedure Consent Form

ALL SEACOAST
DENTAL ASSOCIATES

Patient's Name _____ Doctor's Name _____

I authorize the above-named doctor(s) to perform the treatment/procedure(s) described below. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

The treatment or procedure suggested include the following: check ◯

- ◯ Treatment of diseased or injured teeth with dental restorations (fillings)
- ◯ Extraction of one or more teeth
- ◯ Root canal therapy
- ◯ Build up of tooth or teeth for crowns or bridges
- ◯ Placement of crowns, bridges

I understand that sometimes it is not possible to match the color of natural teeth to the 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 crown, or bridge, including size, shape, fit and color, will be before cementation. **(Initials_____)**

Treatment risks/unwanted consequences of the proposed prosthodontic treatment may be (but are not limited to):

- Adverse reaction to medication / anesthetic
- Numbness induced from pressure of a removable denture requiring adjustment or other procedure
- Potential for root canal treatment after tooth preparation
- Need for periodontal treatment / home care responsibilities
- Breakage of appliance / porcelain fracture
- Recurrent decay
- Bear of teeth that oppose prosthesis (opposite jaw)
- Temporomandibular joint dysfunction due to changes in bite which may require additional treatment
- Stability / movement of appliances (including retention of movable appliance)
- Damage to adjacent teeth or restorations
- Root fracture after root canal treatment
- Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas

I hereby give my consent to any advisable and necessary dental procedure, medications, or anesthetics to be administered be the attending dentists or by the supervised staff for diagnostic purposes or dental treatment. If any unforeseen condition should arise, I authorize the doctor to do what is deemed advisable. I understand that dentistry is not an exact science and that therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made to me by anyone regarding the dental treatment suggested and authorized. I have had the opportunity to read this form and ask question. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient signature _____ Date ___/___/_____

Doctor signature _____ Date ___/___/_____

Witness Signature _____ Date ___/___/_____