William A. Howland, DMD
Meredith Traube, DMD
Consent for Dental Treatment

Patient's Name _____ **Date** _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

___ 1. Treatment: I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, and Extractions, Impacted tooth removal, Root Canals, Mini Implants, treatment of periodontal disease or other work deemed necessary.

___2. Drugs and Medications: I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. **I have informed the doctor of any known allergies.** Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

___3. Risks of Dental Anesthesia: I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with "shots." About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

___4. Fillings: I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

___5. Crowns, Bridges, Inlays and Onlays, Root Canal Therapy: I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that nay changes I may desire in color, shape, size, etc. to a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand that I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility. I realize root canal therapy has a very high success rate; however there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include: extensive decay making the tooth unreasonable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't' be diagnosed earlier leading o persistent and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy are not enough and might need further surgery or treatment by a specialist, resulting in additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away might lead to fracture of the tooth and possible extraction.

Consent: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. My signature below signifies that I understand treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's or Guardian's Signature _____ **Date** _____