

## Informed Consent for Dental Treatment

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

### **X-rays:**

**Proposed treatment:** taking of intraoral (inside the mouth) and extraoral (outside the mouth) radiographs.

**Benefits of treatment:** taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.

**Alternatives of treatment:** none; limited visual examination.

**Common Risks:** minimal radiation exposure to soft and hard tissues of the head.

Consequences of not performing the treatment: missed diagnosis, possible loss of tooth/teeth

### **Cleaning (prophylaxis):**

**Proposed treatment:** involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line.

**Benefits of treatment:** healthy oral environment; also, reduction/elimination of bleeding, odor and periodontal disease.

**Alternatives of treatment:** referrals for periodontal (gum) surgery according to the severity of condition.

**Common risks:** bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.

**Consequences of not performing the treatment:** discontinued or interrupted treatment could result into further inflammation and infection of gum tissues, lead to tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

### **Anesthetic:**

**Proposed treatment:** injection of anesthetic to surrounding oral tissues.

**Benefits of treatment:** numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation.

**Alternatives to treatment:** dental restorations performed with no anesthetic resulting in severe sensitivity and pain.

**Common risks:** allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising and may cause temporary or permanent paralysis.

Consequences of not performing the treatment: severe pain and sensitivity.

### **Fillings:**

**Proposed treatment:** to remove dental caries and replace with filling material to regain proper tooth anatomy.

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**Benefits of treatment:** restore tooth structure for proper function.

**Alternatives of treatment:** temporary filling, crown, extraction.

**Common risks:** allergic to filling material, tooth sensitivity, filling may come out.

**Consequences of not performing the treatment:** further spread of decay, requiring root canal treatment or severe destruction resulting in tooth loss.

#### Amalgam (Silver) VS. Composite (Tooth Color):

Amalgam advantages include; Strong, can stand up to biting force, cost effective, resistance to further decay is high, risk of sensitivity is lower, long lasting.

Disadvantages include; less attractive than tooth color alternatives, placement may require removal of healthy tooth structure, corrosion may darken the appearance.

Composite advantages include; Color and shade can be matched to the teeth, permits preservation of as much tooth structure as possible, frequency of repair is low.

Disadvantages include; Can break or wear out quicker than silver, more expensive, may leak over time requiring replacement, can create sensitivity to cold.

#### Root Canal Treatment/ Pulpotomy:

**Proposed treatment:** to remove infected pulp tissue and replace with root canal filling material.

**Benefits of treatment:** eliminate pain, infection, swelling and further destruction of tooth structure.

**Alternatives of treatment:** extraction.

**Common risks:** recurrence of symptoms, breakdown of tooth structure.

**Consequences of not performing the treatment:** increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

#### Crown and Bridge:

**Proposed treatment:** to strengthen a tooth damaged by decay or previous restoration, and protect a tooth that has had root canal treatment. Improve the biting surface, appearance of damaged, discolored, poorly spaced and/or missing teeth.

**Benefits of treatment:** to restore or improve the appearance and strength of teeth.

**Alternatives of treatment:** extraction or Orthodontic treatment (only in proper spacing, not damaged teeth).

**Common risks:** irritation to surrounding tissue, inflammation, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment.

**Consequences of not performing the treatment:** further destruction, nerve exposure, loss of tooth function, root canal treatment.

#### Tooth Extraction:

**Proposed treatment:** complete removal of a tooth from the mouth

**Benefits of treatment:** to relieve symptoms and/or permit further planned treatment

**Alternatives of treatment:** depending on individual treatment needs: root canal treatment, periodontal therapy, crown or filling, no treatment



**Common Risks:** as with any surgical procedure; discomfort, bleeding, swelling, possible damage to adjacent teeth and/or soft tissue, transient numbness of the jaw **Consequences of not performing the treatment:** increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

I have read and understood the entire information on this consent form, which includes x-rays, cleaning, anesthetic, fillings, root canal treatment, crown and bridge, tooth extraction and dental implants. All my questions were answered to my full understanding and satisfaction. I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all of my questions answered before making a decision.

Further, I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

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Patient/ Parent / Guardian Printed Name

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Relationship to Patient

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Patient/ Parent/ Guardian Signature

\_\_\_\_\_  
Date

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Witness Printed Name

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Witness Signature