Beaufort Family Dentistry

GENERAL DENTISTRY CONSENT FORM

Welcome to Beaufort Family Dentistry! We would like to assure you that everything possible will be done to give you excellent dental hygiene treatment. Following is a description of the Office's operation.

Certain medical conditions require clearance from your physician before we can perform any procedures that will involve bleeding. Under no circumstances will we jeopardize your health or well-being by performing treatment on you without medical clearance, if it is indicated.

SERVICE:

REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) 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 of having teeth removed, some of which are pain and swelling. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

CROWNS AND BRIDGES: 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, which may come off easy 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 shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bride. I understand that there will be additional charges for remakes due to delaying cementation.

ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

PERIODONTAL DISEASE: I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking and dental procedure may have future adverse effect on my periodontal condition.

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 extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for the delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly 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 hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court cost, that may be incurred to satisfy this obligation.

Signature of Patient _____ Date _____