Isla Dental

201 S Rogers Road
Irving TX 75060
Phone: (972) 213 – 0045
Fax: (972) 600 – 8465

Patients Name: _____

DOB: _____

ID #: _____

DENTAL TREATMENT CONSENT FORM

[_____] I ATTEST THAT I AM THE LEGAL PERMANENT GUARDIAN OF THE PATIENT

[_____] WORK TO BE DONE
I understand the following work done: Fillings____ Prophylaxis ____ Extractions____ Sealant____ Impacted teeth extraction____ Local Anesthesia____ Nitrous Oxide Sedation____ Therapeutic Pulpotomy____ Other_____

[_____] X-RAYS, PHOTOGRAPHS AND PREVENTATIVE CARE
X-rays and photographs may be necessary to document and diagnose dental decay and oral hygiene. I understand that x-rays and photos are private clinical records and will not be shared with anyone but the patient/guardian. I consent to diagnostic and preventative care including x-rays, intraoral photographs, dental prophylaxis, fluoride treatment, sealants and full mouth debridement if necessary for diagnostic purposes.

[_____] MEDICATIONS
I consent to the use of medications necessary to the treatment of dental treatment. I have had the chance to ask the dentist questions regarding the medication used. I understand there is a risk of allergic reaction to all medications. I consent to the use of Local Anesthesia for my dental treatment. I understand that Local Anesthesia may contain epinephrine, and have advised my dentist if I have any cardiac disease. Medications may include local anesthesia, sedatives, analgesics, and antibiotics, anti-inflammatory.

[_____] CHANGES OF 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, the most common being root canal therapy following routine restorative procedures. I hereby give my permission to the Dentist to make any/all changes and additions as necessary. If the treatment plan changes during my visit:

☐ I DO wish to continue with changes in treatment at the dentist's discretion.

☐ I DO NOT wish to continue with changes in treatment at the dentist's discretion.

[_____] FILLINGS
I understand that tooth decay requires a filling to replace missing tooth structure. I understand that I will be receiving a resin composite filling, and have discussed the options with my dentist. I understand that a larger filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

[_____] REMOVAL OF TEETH
Alternatives to removal of teeth have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary. I understand removing teeth does not always remove all of the infection. If infection persists further treatment may be necessary. 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 that 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.

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[_____] DENTURES: COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of acrylic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size placement and color) will be in the "teeth in wax" try-in visit. I understand that most dentures require relining approximately 3-12 months after final placement. The cost for such procedure is not included in the initial denture fee.

[_____] CROWN AND BRIDGE
I understand that sometimes it is not possible to match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily. I understand 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, bridge, or cap (including shape, fit, size and color) will be prior to cementation. I understand that any removal or alteration of tooth structure may increase the risk of the need for root canal therapy.

[_____] PULPOTOMY
I realize there is no guarantee that pulpotomy/pulpectomy treatment will save my tooth, and that complications can occur from the treatment. I understand I need a pulpotomy/pulpectomy because of decay extending into the pulp, pulpitis, or necrosis of the pulp. I realize that the coronal tissue is being removed from the teeth as a therapeutic measure due to deep decay that may be near or into the pulp space. I understand that this tooth had a poor prognosis prior to the treatment, due to the extent of the decay, and there is a risk that the tooth can become infected and there may be a need to remove the tooth in the future.

[_____] STAINLESS STEEL CROWNS
I understand that I need a stainless steel crown to cover the entire tooth due to decay, fracture or pulpotomy. My crown is made of stainless steel and these crowns are silver in color; I further understand that they will not have a perfect fit on the tooth due to the fact that they are prefabricated. As a result there is a potential that food and debris may get caught under the crowns that might cause irritation of my gums and my teeth and may lead to an infection or the loss of my tooth. I understand that I need to floss and brush at least twice a day and keep these crowns clean so that they do not get infected. I have discussed the treatment options with my Dentist. If the crown is dislodged, I understand it is my responsibility to notify the office ASAP, to have the crown cemented. Failure to notify my dentist of a crown falling off may result in new office visit to have a new SSC placed. Crowns may need adjustment for proper occlusion.

[_____] ENDODONTIC TREATMENT
I realize there is no guarantee that a root canal treatment will save my tooth, and that complications can occur from the treatment. Occasionally metal files may break in the root canal, which does not necessarily affect the success of the treatment. I understand I need a pulpotomy/pulpectomy because of decay extending into the pulp, pulpitis, or necrosis of the pulp. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand I also have the option of seeing a specialist.

[_____] PERIODONTAL TREATMENT
I understand that I have been diagnosed with periodontal disease (mild, moderate or severe) causing gum and/or bone infection/loss. I understand that periodontal disease is not curable, but therapy to prevent further bone loss and attachments loss has been recommended to me by my dentist. I understand that scaling and root planning (deep cleaning) may help slow the process of this disease, and it is the treatment that is being recommended to me by my dentist. I have been educated that good hygiene is the best way to prevent the progression of periodontal disease, and scaling and root planning, followed by periodontal maintenance is the treatment I am receiving. I also understand that after a deep cleaning there may be severe bleeding of my gingival tissue for an extended period of time. Other risks involve loosening or loss of teeth that were held in place by calculus and tartar. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

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I understand that dentistry is not an exact science. 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/Parent or Guardian:_____

Date: _____