DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form

___1. WORK TO BE DONE
I understand that I am having the following work done: Fillings_____Bridges____Crowns_____Other_____
Initials_____

___2. DRUGS AND MEDICATIONS
I understand that I may receive a local anesthetic and/or other medication. In rare instances, patients may have a severe reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.
Initials_____

___3. CHANGES IN 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. Initials_____

___4. ALTERNATIVES
Alternatives to treatment have been explained to me (root canal therapy, extractions, implants, crowns, periodontal surgery, etc.) and I have no further questions. Initials_____

_____ _____
Patient Signature Date

_____ _____
Dentist Signature Date

_____ _____
Witness Signature Date