Dental Treatment Consent Form
Charlotte Progressive Dentistry

□ Extractions (Removal of teeth)

Alternatives to the removal have been explained to me, and I authorize Charlotte Progressive Dentistry to remove the necessary teeth as indicated on my treatment plan. I have been made aware of which tooth/teeth are going to be extracted and that removal of teeth is an irreversible process. I understand there will be loss of bone around the extraction site and adjacent teeth, as well as, shrinkage of the gingival tissues. I understand there are risks involved and they include, but are not limited to: Pain; Swelling; Bruising; Stretching of the corners of the mouth; Infection requiring further treatment; Dry socket; Damage to adjacent teeth; Nerve injury resulting in numbness or altered sensation (parasthesia) in the teeth, gums, lips, tongue, and chin (sensation most often returns to normal, but may be permanent); Trismus (limited jaw opening); Bleeding; Sharp ridges or bone splinters (may require an additional procedure to remove them); Incomplete removal of the tooth; Sinus perforation; or Fracture of the jaw. I understand that I may need further treatment by a specialist (Oral Surgeon) if complications arise and the costs incurred will be my responsibility.

□ Crowns/Bridges

I understand that sometimes, it is not possible to match the color of natural teeth perfectly. I understand that after my initial crown procedure, a temporary crown will be placed. I understand that sometimes the temporary crown does come off, requiring a return visit to re-cement the temporary crown. I understand that failure to return for re-cementation of the temporary crown may result in the definitive crown not fitting properly. I understand the definitive crown is not a permanent restoration and no guarantees have been made to me about how long it will last. I understand there are risks involved and they include, but are not limited to: Sensitivity of teeth; Future need for root canal therapy; Breakage/Fracture of the crown or tooth.

□ Root Canal Therapy

I understand there is no guarantee that root canal therapy will save my tooth and that complications may arise from treatment. These include, but are not limited to: File separation (breakage of an instrument inside the tooth); Root/tooth perforation; Root fracture; Final fill extending past the root of the tooth; Recurrent infection; Pain; Swelling; Numbness (may be permanent). If a post needs to be placed, I understand there are risks involved including, but not limited to: Root perforation; Crown or Root fracture; Numbness (may be permanent); Loosening or Breakage of the post; Soreness; Sensitivity. I understand that I may need further treatment by a specialist and the costs incurred will be my responsibility.

□ Periodontal Treatment

I understand I have a serious condition causing bone and tissue loss. I understand that this condition may result in the loss of my teeth and even though the utmost care is exercised in the treatment of periodontal disease, there are no guarantees as to the anticipated results. I understand there are risks involved and they include, but are not limited to: Pain; Soreness; Sensitivity; Recession (shrinkage) of gum tissues; Injury to teeth/gum tissues. I understand that I may need further treatment by a specialist (Periodontist) and the costs incurred will be my responsibility. I understand I must keep my periodontal maintenance appointments at the recommended intervals to aid in the retention of my teeth.

□ Dentures/Partials

I understand that full and partial dentures are artificial and usually constructed of acrylic and metal. I understand that problems may arise from wearing these appliances such as: Gum soreness; Looseness; Breakage; Difficulty eating; Difficulty speaking. I understand that the final opportunity to make changes to my new denture/partial will be at the “teeth in wax” appointment. I understand that most dentures/partials require relining approximately 3-6 months after placement. I understand that the cost for this procedure is not included in the initial denture/partial fee. I understand that dentures/partials are not a permanent treatment and no guarantees have been made to me about how long they will last. I understand that once the dentures are made they cannot be returned for a refund.

□ Dental Fillings or Composites

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during tooth preparation. I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that if my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely “permanent” and usually require periodic replacement with additional fillings are/or crowns. I understand I may need further treatment by a specialist and the cost incurred will be my responsibility.

□ Risks of Dental Anesthesia

I understand that pain, bruising and occasional temporary or sometimes permanent numbness in the lips, cheeks, tongue or associated facial structures can occur with local anesthetics. Usually these cases resolve themselves after several weeks. Although very rarely needed a referral to specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve. Any costs incurred will be my responsibility.

By signing this form, I understand that analgesics and other medications, including local anesthetics, can cause allergic reactions resulting in redness, swelling, nausea, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that dentistry is not an exact science and therefore no guarantee or assurance has been made to me regarding the dental treatment I have authorized. I certify that I have read and fully understand the above authorization and informed consent I have had the opportunity to discuss and ask any questions regarding the dental treatment I will receive, and all questions have been answered to my satisfaction. I give my consent willingly to this procedure.

Patient Name:_____

Signature:_____ Date:_____

Patient/Parent/Guardian