SMILE HUB
Dental & Maxillofacial Centre

ISO CERTIFIED DENTAL CLINIC ISO 9001:2015

We love to care for your smile…

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below **Patient Name: _____Patient ID: _____ Age: _____ Sex: ___**

1. **WORK TO BE DONE**
   I understand that I am having the following work done: 1. Fillings 2. Bridges 3. Crowns 4. Extractions 5. Impacted teeth removed 6. Local Anesthesia 7. Root Canals 8. Other Orthodontic Treatment 9. Scaling and Polishing 10. Bleaching 11. Other

2. **DRUGS AND MEDICATIONS**
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. **CHANGES IN TREATMENT PLAN DRUGS AND MEDICATIONS**
   I understand that during treatment it may be necessary to change or add procedures because of condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changed and additions as necessary.

4. **REMOVAL OF TEETH**
   Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and I authorize the dentist to remove the following teeth_____ or **i**mpaction (Surgical extraction of tooth) of following teeth_____ and any others necessary for reasons in paragraph #3. 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 involved in having teeth removed, and 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 of months) or fractured jaw. I understand 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.

5. **CROWN, BRIDGES AND CAPS**
   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 easily 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 new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

6. **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, include looseness, soreness and possible breakage. I realize the final opportunity to make changed in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of the procedure is not included in the initial denture fee.

7. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, 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).

8. **PERIODONTAL LOSS (TISSUE & BONE)**
   I understand that I have a serious condition, causing gum and bone infection 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 any dental procedures may have a future adverse effect on my periodontal condition.

9. **ORTHODONTIC TREATMENT**

I have been explained all the aspects of the treatment in detail (Pro and Cons), I am aware of each and every possible complication regarding my treatment. If, unfortunately I meet with any complication, neither the operating Doctor nor any of his staff will be responsible in terms of legal issues

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the Smile Hub. These procedures include, but are not limited to; examinations, oral prophylaxes(cleaning), fluoride treatments, sealants, restorations (amalgam or composite

fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

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