COMMUNITY HEALTH SYSTEMS, INC.

Dental – Consent for Treatment

Patient Name:_____ **DOB:**_____

1. WORK TO BE DONE
I understand that I am having the following work done today:

Treatment(s)	Patient Initials and Date	Treatment(s)	Patient Initials and Date	Treatment(s)	Patient Initials and	Treatment(s)	Patient Initials and Date
Exam/Lim. Exam ***(emergency)***		***X-ray(s)***		***Filling(s)***		***Sealant(s)***	
Tooth #(s) /Quad:		Tooth #(s) /Quad:		Tooth #(s) /Quad:		Tooth #(s) /Quad:	
Consultation(s)		***Extraction(s)***		***Root Canal(s)***		***Crown(s)***	
Tooth #(s) /Quad:		Tooth #(s) /Quad:		Tooth #(s) / Quad:		Tooth #(s) /Quad:	
Other-(specify)		***Scaling and Root Planning***		***Cleaning(s)***		***Fluoride***	
Tooth #(s) /Quad:		Tooth #(s) /Quad:		Tooth #(s) /Quad:		Tooth #(s)/Quad:	

2. EXAM / LIMITED EXAM
I understand that to properly assess my oral health that an exam is necessary.

3. X-RAYS
I understand the use of x-rays is necessary to be able to identify caries between the teeth and/or to assess health of the root structure of my teeth to include their bone levels.

4. SCALING AND ROOT PLANNING
I understand that that this procedure is necessary in order to remove the build up from around my teeth and root structures.

5. DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, itching, vomiting and/or anaphylactic shock.

6. 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 the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make all/any changes and additions as necessary.

7. 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 and any others necessary. I understand removing teeth does not always remove all the infection, if present it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue (Paraesthesia) that can last for an indefinite period of time or fractured jaw.

I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

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8. 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 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 within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

9. 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 root canal filling material may 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). I understand that the tooth may be lost despite all effort to save it.

10. PERIODONTAL DISEASE (TISSUE & BONE LOSS)
I understand that I have a potentially 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, replacement and/or extractions. Every effort will be made to help you improve your periodontal health. However, you may still need to see a periodontist (gum specialist) for further treatment.

11. 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. Post-operative sensitivity may be more pronounced with composite fillings. Also, composite fillings may discolor over time from food, coffee, soda etc. Amalgam shavings may accidently get into the surrounding gum tissue, resulting in gray spots to tattoos. Teeth may also become gray or darker in appearance when adjacent to amalgam.

12. PULPOTOMY/PULPECTOMY (Partial Nerve Rem/Full Nerve Removal)
Once decay reaches the nerve (pulp of the tooth), the tooth cannot be restored by a filling alone, patient may experience pain or swelling at this time. If during decay removal, the dentist realizes that the decay has reached the nerve, then a pulpotomy must be performed to prevent further problems. After a pulpotomy, the baby tooth is more brittle and may require a stainless-steel crown as coverage. The tooth may need further treatment in the future, such as extraction and/or space maintainer.

13. PRIMARY CROWN
Providers full coverage of the damaged (decayed, fractured) baby tooth. Stainless steel crown provides strength and reliability. White crown option for front teeth are fragile and care should be taken to avoid breaking of material.

STATEMENT

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee of assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatment explained to me. I understand that this is only an estimate and is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Patients Signature:_____ **Date:** _____

Provider's Signature:_____ **Date:** _____

Witness' Signature:_____ **Date:** _____