



## **GENERAL DENTAL TREATMENT CONSENT FORM**

In order to minimize paper trail, I authorize any necessary dental treatment (as needed and upon verbal consent), advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia for the complete length of time I am a patient at The Smile Fairy Dental Spa.

In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, partials, dentures, etc.)
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root, also known as "endodontic" therapy or root canal and/or Gross Pulpal Debridement.

**Risk of Dental Procedures in General** - Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Temporomandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

**Changes in Treatment Plan** - I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give me permission to the dentist to make any/all changes and additions as necessary.

**Fillings** - I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

**Crowns (Caps), Bridges and Onlays** - I understand that sometimes it is not possible to match the color of artificial teeth with natural 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 realized the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

**Alternative Treatment** - I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. By signing below, I consent to the general treatments and/or proposed treatment plans presented.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Name (Printed): \_\_\_\_\_