Dental Treatment Consent Form

Patient Name	:	Reshma Siya			Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	: 1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	: Alan Alfred	Date	:	2024-03-02

****Please read and sign at the bottom of form.

☐ **1.X-RAYS**

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

☐ **3. CHANGES IN TREATMENT PLAN -** I understand that during treatment it may be necessary to change or add procedure 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 procedure. I give my permission to the Dentist to make any/all changes and additions as necessary.

☐ **4. REMOVAL OF TEETH -** Alternative to removal has been explained to me (Root canal therapy, crowns, periodontal surgery, etc.) and I authorize the dentist to remove the following teeth. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months) or fractured jaw.

☐ **5. CROWNS, 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 that I must be careful to insure 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) before cementation.

☐ **6. 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).

☐ **7. 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 expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

☐ **8. DENTURES, COMPLETE OR PARTIAL -** I understand the wearing dentures are difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I stand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. I realize that full or partial dentures are artificial, constructed of plastic, metal, and /or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage.

☐ **9. IMPLANT -** I understand thatthe surgical placing of implant is possible and has high success rate, but has no guarantee of success can be assured for this kind of treatment; About classical treatment by way of fixed prosthesis or affixed prosthesis (removable) suitable to my case; Of the necessity of bi-yearly clinical and radiographical controls during the three years that follow the placing of implants, and yearly ones afterward; That incase of failure, the implant will be removed at no further cost.

☐ I, the undersigned, certify that I am rightfully informed by my dentist about my x-rays, drugs and medications, the dental treatment plan and that I am medically fit to do the treatment, the dental procedures, the price, the complications it may arise.I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Sign here, only if all of your questions have been answered to your satisfaction	
Signature of Patient	Date 2024-03-02
Signature of Parent/Guardian if patient is minor	Date 2024-03-02
For clinic information, how did you come to know our clinic? Please mention the name.	

Magazine	School:	Establishment:
Insurance Company		Your Staff/Friend/Relative: