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Treatment Consent Form

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

What you are being asked to sign is confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives, and that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.
2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3. I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there will be additional fees related to the additional time Normal and usual treatment consists of 1 or 2 try-ins of the restoration and up to 5 post-insertion adjustments.
4. I understand that Dr. Calcagno has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.

5. I have been informed of the possible risks and complication involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.
6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.
7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and /or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
8. Dr. Calcagno has explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

9. I agree to follow the home care instructions provided to me. I agree to report to Dr. Calcagno for regular examinations as indicated and I understand that this office will monitor my progress.10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, anesthetics, pollens, dust, any blood or body diseases, gum or skin

reactions, abnormal bleeding or any other conditions related to my health.11. I consent to photography and X-rays of the procedure to be performed for the advancement of dentistry, provided my identity is not revealed.12. I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove the bacterial plaque off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail.13. I understand that X-rays will be taken before, during and after treatment. A number of X-rays are required during the course of therapy and as every situation is different, it is impossible to estimate the cost of the radiographs. I understand that I will be charged for the radiographs in addition to my proposed treatment plan.

For Patients having Implant Treatment the following also apply:

1. I understand that Dr. Calcagno has carefully examined my mouth. Alternatives to implant therapy have been explained. I have tried or considered these methods, but I desire an implant to help secure the replacement restoration for my missing teeth.
2. I have been informed of the possible risks and complications involved with implant prosthetics that include but are not limited to the following: implant fracture, screw loosening or fracture, acrylic or porcelain fracture and cement failure.
3. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow the home care instructions provided to me. I agree to report to Dr. Calcagno for regular examinations as indicated.

For all Patients:

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

For all patients having implant treatment:

I have been fully informed of the nature of implants and implant surgery, therapeutic risks and prosthodontic treatment alternatives to oral implants and hereby consent to treatment.

For Patient/Guardian:

Signature: ______________________ Date: [ ]

Signature of Doctor:

Signature: ______________________ Date: [ ]

Signature of Witness:

Signature: ______________________ Date: [ ]

Response Date: [ ]