MAV
DENTISTRY

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1. SCOPE OF TREATMENT

I understand that I am having the following procedures performed: Fillings ( ), Bridges ( ), Crowns ( ), X-Rays ( ), Extractions ( ), Impacted Teeth Removal ( ), Root Canals ( ), Dentures ( ), Other:_____ (1) Initials: _____

2. MEDICATION REACTIONS

I understand that antibiotics, analgesics, and other medications may cause allergic reactions, including redness, swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (2) Initials: _____

3. CHANGES IN TREATMENT PLAN

I understand that unforeseen conditions may require changes or additions to my treatment plan. For example, a root canal may become necessary following routine restorative procedures. I authorize my dentist to make any/all necessary changes and additions. (3) Initials: _____

4. TOOTH REMOVAL AND ALTERNATIVES

Alternatives to tooth removal (e.g., root canal therapy, crowns, periodontal surgery, etc.) have been explained to me. I authorize the dentist to remove the following teeth: _____ and any others deemed necessary due to conditions mentioned in Paragraph 3. I understand that removing teeth may not eliminate all infections, and additional treatment may be required. Risks include pain, swelling, spread of infection, dry socket, loss of sensation (Paresthesia), or fractured jaw. I understand specialist treatment may be needed in case of complications, at my own expense. (4) Initials: _____

5. CROWNS, BRIDGES, AND CAPS (RESTORATIVE WORK)

I understand that color matching for artificial teeth may not always be exact. I may wear temporary crowns which may come off easily and I must ensure they are kept on until the permanent crowns are delivered. I understand that final changes to my crown, bridge, or cap (including shape, fit, and color) must be made before cementation. I agree to return for permanent cementation within 21 days from tooth preparation; delays may cause tooth movement, necessitating a remake with additional charges. (5) Initials: _____

6. ENDODONTIC TREATMENT (ROOT CANAL)

I understand that root canal therapy may not always save a tooth and that complications may arise from the treatment. Occasionally, the root canal filling material may extend beyond the tooth, which does not necessarily affect the treatment outcome. I understand that surgical files are fine instruments and stresses from manufacture can cause them to separate during use. I understand that surgical procedures, such as an apicoectomy, may be needed following treatment, and the tooth may be lost despite efforts to save it. (6) Initials: _____

7. PERIODONTAL TREATMENT (TISSUE & BONE)

I understand that I have a condition affecting gum and bone health, which could lead to tooth loss. Treatment options, including gum surgery, replacement, and/or extractions, have been explained to me. I understand that any dental procedure may impact my periodontal health in the future. (7) Initials: _____

8. FILLINGS

I understand that I should avoid chewing on new fillings for 24 hours to prevent breakage. Additional decay may necessitate a more extensive filling than initially diagnosed, and sensitivity is a common side effect after a new filling. (8) Initials: _____

9. DENTURES

I understand that dentures may cause sore spots, alter speech, and make eating difficult. Immediate dentures, placed right after extractions, may be painful, may require adjustments, and many relines. A permanent reline, which is not included in the denture fee, will be needed later. It is my responsibility to attend the delivery appointment, I understand that failure to keep my delivery appointment may result in poorly fitted dentures, and delays exceeding 30 days may result in additional charges for a remake. (9) Initials: _____

10. AUTHORIZATION, PAYMENT, AND LEGAL AGREEMENT

I authorize the dentist and any assisting staff to proceed with the necessary treatments as explained. I understand that this is an estimate and may be modified based on new findings during treatment. Regardless of insurance coverage, I am responsible for payment of dental fees. I agree to pay any attorney's fees or court costs incurred in collecting payment. (10) Initials: _____

Patient/Guardian Printed Name: _____

Signature of Patient/Guardian: _____ Date:_____

Signature of Dentist: _____ Date:_____