

**Water Tower Dental Care P.C.**  
Consent for Dental Treatment

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**I hereby consent/ refuse to the following described dental procedures upon me by or under the direction of Water Tower Dental Care, their associates and assistants.**

I acknowledge that the following information has been provided to me.

Nature of my dental illness: Periodontal Disease, Abscessed tooth, Cracked Broken tooth, Teeth with failing restorations, Unrestorable teeth, Decayed teeth, Missing teeth, Posterior (back) bite collapse, Bite Problems.

The purpose of the following procedure is to correct, restore or improve the above conditions.

Treatments: I understand that I am having selected dental treatment done: (please read and initial the items checked below)

**Anesthesia and medications**

I consent to administrations of local anesthesia and other drugs deemed necessary in my case and understand the risks of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/ or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetic.

Initials: \_\_\_\_\_

**Periodontal therapy (Periodontics)**

I understand that I have a serious condition causing gum and bone infection or loss that can lead to the loss of my teeth. Alternative treatment has been explained to me including gum surgery, tooth replacements and/or extractions. I understand that not undertaking any dental procedure may have a future adverse effect on my periodontal condition.

Initials: \_\_\_\_\_

**Root Canals (Endodontics) and Posts**

I realize there is no guarantee that root canal therapy and posts will save my tooth, and that complications can occur from the treatment. Complications can include breakage of metal objects in the tooth and over extension of cement or filling materials outside the root tip that may result in permanent nerve damage. I understand that although rare, perforations (going out the side of the tooth) can occur. I am also aware that, after root canal therapy a crown or onlay will need to be placed on the tooth.

Initials: \_\_\_\_\_

**Tooth Colored Fillings (composites)**

I understand that my teeth need new or replacement fillings. Certain side effects can include hot, cold, and/or biting sensitivity (pressure). With larger cavities, root canals and/or crowns may be necessary to stabilize my tooth/teeth. (Occasionally a "high spot" in your bite may develop after the numbness has worn off. If this occurs please contact our office immediately for an adjustment of the "high spots"). I understand it is sometimes not possible to match the color of natural teeth exactly with artificial filling materials.

Initials: \_\_\_\_\_

**❑ Porcelain Crown/ Bridge/ Veneer**

I understand that I may be wearing a temporary restoration(s), which may come off easily, and that I must be careful to ensure they are kept in place until the final custom restoration(s) are placed. I further understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand the final opportunity to make changes in my new crowns/bridges/veneer in color, shape, fit or size occur before cementation. I realize that some crowns/ bridges/ veneers are used to treat decay and fracture and therefore, root canal therapy maybe required during or after treatment if symptoms arise.

Initials: \_\_\_\_\_

**❑ Partial and Complete Dentures**

I realize that complete or partial dentures are artificial and are constructed of plastic, metal and/or porcelain. The potential concern in wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including fit, size, placement, and color) will be the "Teeth in Wax" visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of this procedure is not included in the initial denture fee. I also understand that all adjustments are included for one month following the placement of the denture. Any future adjustment will have a fee.

Initials: \_\_\_\_\_

**Financial Responsibility** I understand that dental treatment is an excellent investment in an individual's medical and psychological well-being and financial considerations should not be an obstacle to obtaining this important health service. In their efforts to make their services more affordable for the patients, they have several forms of payment. Regardless of method of payment I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers compensation and the like. I also agree to pay for services when they are rendered unless other arrangements have been made with the financial coordinator. I understand that financial charges will be added to my account for delinquent payments at the rate of one and one-half percent per month on the total balance. I further agree to pay for attorney's fees and collection costs in the event I fail to pay or my insurance fails to pay my account in full within 90+ days of receipt of services.

I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have requested authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with the doctors at Water Tower Dental Care P.C., their associates or assistants and that I understand the information provided.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_