New England Dental
Family Dentistry • Se Habla Espanol • Falamos Portuguese

INFORMED CONSENT / PROSTHODONTIC TREATMENT

Dr_____ has explained the benefits and risks of dental prosthetic treatment to me. Referral to a specialist (Prosthodontist) has been offered. Dental prosthetic appliances may be fixed or removable. They are designed to replace missing teeth. They are made of variety of materials and various alternative have been explained to me including the benefits of each alternative available. I understand that appliance may wear at different rates and may need replacement or re-fitting. Appliance to replace teeth includes full denture, partial dentures and fixed bridges. They are retained in the mouth by a variety of methods. The specific design for the appliance (including possible alternative) have been explained to me.

Fixed dental prosthetics, if proposed, including crowns (covering the entire tooth), inlays, onlyas, and laminates have been explained including the proposed materials to be used and alternatives available. Removable appliance, if proposed, have been explained to me, including the materials involved. I understand removable dentures will not chew as efficiently as natural teeth and may acquire stains, odor, retain food in certain spots and require relines in time due to changes in the gum tissue and underlying bone.

I understand and accept the treatment recommended for me by Dr._____.I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Alternative treatment (s) and the option of no treatment has been explained to me. I understand the risks of no treatment may include, but are no limited to, problems with the bite and periodontal disease related to teeth that have changed position and/or are under stress. All of my questions have been addressed.

Proposed fees have been explained to me, as have any third party insurance benefits. I understand that third party benefits mat be different than discussed by Dr._____as they are not under the control of this office.

Treatment risks / unwanted consequences of the proposed Prosthodontic treatment may be (but are not limited to):

- Reaction to medications / anesthetic
- Numbness induced from pressure of a removable denture requiring an adjustment or other procedure
- Potential for root canal treatment after tooth preparation
- Need for periodontal treatment / home care responsibilities
- Breakage of appliance / porcelain fracture
- Recurrent decay
- Wear of teeth which oppose the prosthesis (opposite jaw)
- Changes in speech
- Temporomandibular joint dysfunction due to changes in the bite, which may require additional treatment
- Stability / movement of appliance (including retention of removable appliance)
- Damage to adjacent teeth or restoration

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient name:_____Patient ID#_____

Patient (or Legal Guardian's) Signature_____Date _____

Witness _____ Date _____

Dr Signature _____ Date _____

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