DENTAL TREATMENT CONSENT FORM

_____7. **Periodontal Disease:** Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____8. **Root Canal Therapy:** I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not effect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not effect success. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise.

_____9. **Changes in Treatment Plan:**
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care.

_____10. **Alternative Treatment(s):**
Include:_____
_____
_____
_____
_____

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date