



Project
Outback
Dental
(POD) Pty Ltd®

DENTAL TREATMENT CONSENT FORM

Patient Name: _____

Appointment Date: _____

Please read and initial the items provided below and read and sign the section at the bottom of the form.

I consent to _____ DENTAL CHECKUP ONLY _____ DENTAL CHECKUP AND TREATMENT
(Please continue reading below).

1. **WORK TO BE DONE**

I understand I am having the following work done: Filling _____ Crowns _____
Extractions _____ Impacted teeth removed _____ General Anaesthesia _____
Root Canals _____ Other _____

(Initials _____)

2. **DRUGS AND MEDICATION**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or severe allergic reaction (anaphylactic shock).

(Initials _____)

3. **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being the root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions necessary.

(Initials _____)

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorise the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph 3. I understand that removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalisation if complications arise during or following treatment.

(Initials _____)

5. **CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match colour of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realise the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and colour) will be before cementation.

(Initials _____)

6. **DENTURES**

I realise that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, and possible breakage. I realise the final opportunity to make changes in my new denture (including shape, fit, size, placement, and colour) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three or twelve months after initial placement. The cost for this procedure is not included in the initial denture base.

(Initials _____)

7. **ENDODONTIC TREATMENT (ROOT CANAL)**

I realise there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials _____)

8. **PERIODONTAL LOSS (TISSUE AND BONE)**

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth, Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

I understand that dentistry is not an exact science and that, therefore even reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested an authorised. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date: _____

Signature of Parent/Guardian _____ Date: _____