Sonnier Dental
Dental Treatment Consent Form

Name: _____ **Date**: _____

Treatment Plan
I understand that the dental office will present and discuss all dental procedures with me that need to be performed. It is my responsibility to ask any questions about my dental treatment. I give consent to all procedures once I fully understand the treatment to be rendered. Initials:_____

Drugs and Medications
I understand that I may be prescribed antibiotics, pain medications, mouth rinses and other medications that can cause adverse reactions. In the event the reaction causes redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock I am to discontinue the medication immediately and contact the dental office and/or call 911. Initials:_____

Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination. A filling could turn into a root canal or crown following routine restorative procedures. I hereby give my permission to the Dentist to make any/all changes and additions as necessary. Initials:_____

Prior To Treatment

Caffeine/Medications
I understand that certain foods, beverages, medications or other substances may decrease the efficacy of dental anesthesia and I should avoid them prior to my appointment. Examples are caffeine, antihistamines, anti-depressant medications and other substances. It is my responsibility to ask the office if I am not sure. I understand that I should eat a hearty meal prior to my appointment. Initials:_____

Pre-Med - Amoxicillin/Clindamycin. I understand that if I need to have antibiotic prophylaxis prior to my dental appointment I need to let the office know and a prescription will be called in prior to my visit. Initials:_____

Sedative – (Valium). I understand due to dental anxiety I have the option to request valium prior to my dental appointment. I understand that this is a prescription that has to be called in. It is imperative that I have a driver transport me to and from my visit. Initials:_____

Nitrous Oxide (Laughing Gas) is also an option that would be administered during my appointment. It is administered in 15-minute intervals. Initials:_____

Fillings

Amalgam(silver)
I understand that I have decay or fractured a tooth that indicates a restoration needs to be done. I understand amalgam restorations consist of several different metals and are classified a safe compound. In rare cases they may cause allergic reactions or stains to the tooth or gum tissue. Amalgam restoration may last longer and are relatively inexpensive. I hereby authorize the dentist to place amalgam restorations. Initials:_____

Resin(white)
I understand that I have decay, a fracture or space that needs to be closed that indicates a restoration needs to be done. Resin restorations are a fluoride-based material that requires a bonding agent and a curing light. Great option because resin restorations are more cosmetic. I understand that increased sensitivity may result with resin restorations. I also understand that resin restorations are not recommended for very large carious lesions because they are more susceptible to fracture and/or leakage. Crowns or root canals may be indicated. I hereby authorize the Dentist to place resin restorations. Initials:_____

Major Restorations

Crowns (Caps)
I understand that I have large decay, a fractured tooth, a root canal or want cosmetic dentistry that indicates a crown. Sometimes tooth shade and contours of the crown may not be an exact match to your natural tooth. I understand my tooth will be prepared for a crown and a temporary crown will be placed. The temporary crown is made to protect the tooth and to maintain the space for proper placement of the crown. I understand that if the temporary comes off for any reason it is my responsibility to have it replaced immediately because the remake of the crown will be my financial responsibility because the tooth shifted. Initials:_____

Bridges
I understand that a bridge is a series of crowns linked together to replace a missing tooth or teeth. I understand that some of my teeth may be compromised in order to prepare for this prosthesis. I further understand that a bridge is a longer span than a single crown which may cause more stress and/or torque on the teeth associated with the bridge. I hereby authorize the Dentist to place a bridge. Initials:_____

Implants
I understand that an implant is a root formed titanium post that is placed in bone to replace missing teeth. This option is treatment of choice because the adjacent teeth do not have to be compromised. I understand there will be a healing period in which I may or may not be wearing a temporary prosthesis. Once the healing process is complete then I will be ready for the restorative crown or denture that will be placed over the implants. I further understand that any procedure outside

the implant (including crowns and dentures) will be an additional fee. I hereby authorize the Dentist to place an implant and final prosthesis (crowns and dentures). Initials:_____

Dentures, Complete or Partials

I realize dentures are a removable option to replace missing teeth. The problems of wearing dentures have been explained to me, including, looseness, soreness, and possible breakage. I understand there is an adjustment phase and several adjustments to the appliance may have to made to maximize the fit. Dentures may also require a reline if dentures become too loose. I understand that tooth size, tooth color, and gum tissue shade on partials and dentures may not be the exact size and color of my natural teeth or gums. I hereby authorize the Dentist to deliver dentures. Initials:_____

Endodontics

Root Canals

I understand the decay encroaching the nerve, an abscess or a fractured tooth can indicate the need for a root canal. This is treatment of choice to save a tooth. I realize there is no guarantee that root canal therapy will save my tooth and complications can occur from treatment. Root canals have an 85% success rate. If I become symptomatic after a root canal procedure is done it may be necessary to be referred to an Endodontist or the tooth may be non-restorable and has to be extracted. To ensure the best possible success rate I am to finish the antibiotics prescribed and have the permanent build-up and crown placed within 2 months after completion of the root canal. Initials:_____

Oral Surgery

Extractions

I understand that due extensive decay, fracture, mobility, infection or mal-positioned tooth/teeth an extraction and/or extractions are indicated. Complications may arise to include excessive bleeding, damage to restorations or adjacent teeth, fracture of the lower jaw, root tips dislodged into maxillary sinus, damage to the inferior alveolar nerve that may cause temporary or permanent numbness, post-operative infection or dry socket. I understand that some of these complications may require a referral to an Oral Surgeon this will be my responsibility. It is imperative that I follow all post-op instructions and take prescribed medications on schedule. I hereby authorize the dentist to perform surgery on me. Initials:_____

Periodontics

Scaling/Root Planing (Deep Cleaning)

I understand that I have a serious condition caused by plaque and tartar(calculus) build-up which may lead to gum infection and/or bone loss that can lead to the loss of my teeth. I understand that my entire mouth has to be numbed, a cavitron and hand instruments will be used to remove the plaque and tartar deposits. I understand the success rate of healthy gums and teeth lie with me investing in a rotary toothbrush, brushing and flossing 2-3 times a day and maintaining a 4 month recall cleaning appointment. Healthy gums and bone are the foundation for the overall health of my mouth and the success of all procedures revolve around this. I hereby authorize the Dentist to do a deep cleaning on me. Initials:_____

Orthodontics

Invisalign

I understand that Invisalign are clear removable aligners designed to straighten teeth without doing conventional metal brackets. It is imperative that I change out trays ever 2 weeks to achieve optimal success in the straightening process. I understand additional aligners may have to be placed if alignment is not where the Dentist and I would like it to be. I understand that it is imperative to wear my retainers at the completion of the process all day everyday for 3 months then only at bedtime. Initials:_____

Whitening

Teeth Whitening (Bleaching)

I understand whitening is an option to lighten the shade of my teeth which may have been altered due to genetics, medications, beverages or foods. I understand optimal results can be achieved if I am on a regular cleaning schedule. I understand that I may not be “Hollywood White” but I will be lighter than I was. I understand there are in office and take-home whitening options that may be used in combination with each other. A before and after change will be taken and the success of the treatment will be discussed along with post-op instructions. I hereby authorize the Dentist and/or staff to perform teeth whitening on me. Initials:_____

I understand that dentistry is not an exact science. Therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. 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 _____
Signature of Doctor _____ Date _____