Staley Family Dentistry
4361 Wabash Avenue
Terre Haute, Indiana 47803
812-232-8812

DENTAL TREATMENT CONSENT FORM

Patient Name _____

Please Read and Sign

WORK TO BE DONE

I understand that I am having the following work done:

• Fillings	• Bridge
• Crown	• Extractions
• Root Canal	• Check Up/Exam (Cleaning)
• Consultation	

DRUGS AND MEDICATIONS

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

CHANGES IN TREATMENT PLAN

I understand that during treatment it may become 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 root canal therapy following routine restorative procedures).

REMOVAL OF TEETH

Alternative to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reason in paragraph #1. I understand removing teeth does not always remove all the 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 hospitalization if complications arise during or following treatment.

I understand that dentistry is not an exact science and that, 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 Patient/Guardian if patient is a minor _____ Date _____

24 HOUR NOTICE MUST BE GIVEN OF CANCELLATION
WE RESERVE THE RIGHT TO CHARGE FOR MISSED APPOINTMENTS (MINIMUM $25.00)