

DENTAL TREATMENT CONSENT FORM

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

Patient Name _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Other _____
(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling
of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
(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 root canal therapy following
routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initials _____)

4. REMOVAL OF TEETH

Alternatives 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 reasons in
paragraph #3. 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, the cost of which is my responsibility.
(Initials _____)

5. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection 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, 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 if patient is a minor _____ Date _____

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