

SANDRA GOMEZ-TRAINOR D.D.S

DENTAL TREATMENT CONSENT FORM

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

(Initials : _____)

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 : _____)

DRUGS & 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 : _____)

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: _____