



GENERAL DENTAL TREATMENT CONSENT

1. 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).

2. TREATMENT PLANS

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. If any deviation occurs from the original agreed upon treatment plan, a new treatment plan will be printed for you. You will be given the time to view it and discuss its contents with the doctor.

3. EXTRACTIONS

If the teeth are restorable, the alternatives to removal of teeth are root canal therapy, crowns, and periodontal surgery, etc. 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.

4. FIXED PROSTHESES

I understand that sometimes it is not possible to match the color 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 realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

5. RADIOGRAPHS

I understand that radiographs are essential tools for assessment of my oral health as well as various oral diseases. I authorize King Tooth doctors to use professional judgment to provide the appropriate care.

6. REMOVABLE PROSTHESES

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

7. ROOT CANAL THERAPY

I realize 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.

8. PERIODONTAL TREATMENT & ROUTINE CLEANING

I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

9. SCHEDULING

I understand that due to the nature of dentistry, unexpected situations can arise. Therefore, the doctor(s) of King Tooth will attempt to be as punctual as possible. However, if delays occur, our staff will inform patients promptly, and it is the patient's discretion to wait or reschedule the appointment as needed.

10. FILLINGS

I understand that more extensive restorations than initially planned may be needed due to additional conditions found during the course of treatment. I understand that fillings could cause significant thermal response changes in teeth. I also understand that fillings are rarely permanent and will require periodic replacements.

I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my minor child or myself. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Name: _____
Date: _____
Signature: _____

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