

**DMC DENTAL PRACTICE, INC**  
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**PATIENT RELEASE FORM**

**1) CHANGES IN TREATMENT PLAN.** I understand that as treatment progresses it may be necessary to change or add procedures due to conditions found during the process of treatment that were not readily evident at the exam and diagnosis phase of treatment and of which could require care by a specialist, the cost of which is my responsibility. I give my consent to these changes or additions. I understand that even minor treatment can result in sensitivity and even a routine procedure can necessitate root canal therapy. Initial \_\_\_\_\_

**2) MEDICATIONS & ANESTHETICS.** I understand that antibiotics, analgesics, anesthetics, medications and other dental supplies/products may be part of the treatment and can cause allergic reactions (redness, swelling, pain, itching, vomiting and/or anaphylactic shock) and can change the effectiveness, duration and interact with other medications taken. The injection of the anesthetic can cause temporary or indefinite changes in feeling (parasthesia) and motor control. Initial \_\_\_\_\_

**3. REMOVAL OF TEETH (EXTRACTION).** Alternatives to the removal of teeth have been explained to me as applicable (root canal therapy, crowns, periodontal surgery - etc) and I authorize the removal of Treatment Planned teeth and any others necessary (see paragraph #1). I understand the risks include pain, swelling, discomfort, the spread of infection, dry socket, parasthesia, (a change in feeling in my teeth, lips, tongue and surrounding areas that can be permanent in nature) and/or changes in motor control .I understand that removing teeth does not always remove all of the infection and infection caused changes. These and other complications that may occur during or following treatment may require further treatment by a specialist or even hospitalization, the cost of which is my responsibility. Initial \_\_\_\_\_

**4) ROOT CANAL (ENDODONTIC TREATMENT).** I understand that a root canal is an attempt to save a tooth and that complications (calcified canals, inaccessible canals, perforation & loss of the canal during treatment, instrument separation in the canal and/or fracture of the tooth crown, body or root) can occur. Other complications can include a reaction to a medication used, pain, swelling, continued infection and sensitivity to pressure even after treatment is completed. These and other complications that may occur during or following treatment may require further treatment (including retreatment, surgery on the root and/or extraction) by a specialist, the cost of which is my responsibility. Initial \_\_\_\_\_

**5) FILLINGS.** I understand that as treatment progresses, as in any restorative procedure, the cavity (caries) may be greater than expected. Initial \_\_\_\_\_

**6) INLAYS, VENEERS, CAPS (CROWNS) AND BRIDGES.** I understand that it is not possible to exactly match the color of natural teeth. I realize that the time to request changes (in color, shape, fit and size) is prior to cementation. I realize that permanent crowns are fabricated from materials that can be susceptible to fracture. I understand that the temporary placed interim to the placement of the permanent is fragile in nature and care must be taken not to break or dislodge it. The temporary is constructed to last only two to three weeks; postponing the placement of the permanent can allow tooth movement, necessitating a remake at an additional charge. Initial \_\_\_\_\_

**7) DENTURES-COMplete OR PARTIAL.** I understand problems in wearing dentures can include looseness, sore spots, decreased ability to speak/eat and breakage. Immediate dentures (dentures placed at the time of the extractions) have more discomfort and require additional adjustments. I realize that the time to request changes (in color, shape, fit, and size) is at the "teeth in wax" visit. Relines (at an additional fee) will be required as a denture loosens with tissue shrinkage. Initial \_\_\_\_\_

**8) GUM (PERIODONTAL) TREATMENT.** I understand that I have a serious and progressive disease that can lead to acute infection, pain and tooth loss. Treatment can include cleanings (scaling), deep cleanings (root planning), periodontal surgery (by referral to a specialist) and teeth considered hopeless or teeth that do not respond favorably to treatment will require extraction . I understand that post-therapy, my teeth may be sensitive to cold and sweets. I understand that postponement of care and other factors including the quality of home care can affect my ability to retain my natural dentition. Initial \_\_\_\_\_

**9) IMPLANTS.** I understand that implants have two main parts: an abutment (root form) and a restoration (suprastructure) portion. Poor healing or infection at the surgical site can lead to acute infection, pain and loss of the abutment and/or adjacent teeth. The restorative portion also may come lose or fracture requiring replacing screws or collars, recementation and/or complete loss of the suprastructure. Replacement of the abutment or suprastructure are additional procedures, the cost of which is my responsibility. I understand that smoking greatly increases the risk of abutment failure Initial \_\_\_\_\_

**10) Temporomandibular Joint Dysfunction (TMD)** I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually in nature and well tolerated by most patients, I understand that should the need arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility Initial \_\_\_\_\_

**I understand that dentistry is as much an art as a science and because of this it is impossible to predict the outcome of treatment. I authorize my treating dentist(s) to proceed through the use of medications, materials and therapy as deemed appropriate as treatment progresses. I have no unanswered questions about treatment benefits/risks, or alternative treatment(s) and their benefits/risks**  
**I have read, understand and agree to the above.**

Patient \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_ Date: \_\_\_\_\_

Doctor \_\_\_\_\_ Date: \_\_\_\_\_