Sheila Harris, D.D.S.

PARTIAL OR FULL DENTURE
INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for elective dental treatment. Each item should be initialed after the patients (and/or their parents or guardians) have the opportunity for discussion and questions.

_________ 1. **I, THE UNDERSIGNED, CONSENT TO Dr.___ _____________, his/her partners, associates, dental hygienists, and/or dental assistants performing on me the outlined Treatment Plan (***as outlined on the "Treatment Form" that has been provided to me***).**

_________ 2. **I accept and understand that the procedure(s)** *is/are elective in nature and not treatment for any dental disease***.**

__________ 3. **I accept and understand that although Dr._ _______________ will make every effort to improve my smile to my desires, there are limitations due to function, color, extent of inherent staining, shape and/or placement of the original teeth.**

__________ 4. **I accept and understand that denture (partial or full) treatment results are subjective**; thus, *the outcome of my Treatment Plan may not completely meet my expectations***.**

__________ 5. **I accept and understand that the alternatives to the Treatment Plan, which have been fully discussed with me, include but are not exclusive of:**

___________ **a. Dental implants, endodontic therapy, crowns, bridges**
___________ **b. No Treatment.**

_________ 6. ***Each option has been fully explained to me with its' benefits, risks, pros, cons, and approximate investment cost***. I accept and understand that there are ***risks and limitations*** to all procedures. For this denture (partial or full) treatment these risks and limitations include, but are not exclusive of:

__________ *a. Looseness of denture (partial or full)*
__________ *b. Soreness of gum tissues*
__________ *c. Shrinkage (mild to severe) of gum tissues*
__________ *d. Breakage of denture (partial or full)*
__________ *e. Reline, readjust or replace denture (partial or full) –* ***(at additional costs)***
__________ *f. Change in speech or appearance*
__________ *g. Difficulty wearing denture (partial or full)*

_________ 7. I accept and understand that the denture (partial or full) is/are artificial, and is/are constructed of plastic, metal and/or porcelain.

_________ 8. I accept and understand that denture (full or partial) made within six (6) months of tooth/teeth extraction(s) may become ill fitting as the gum tissues around the extraction site(s) shrink, which may require denture to be relined or replaced.

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_________ 9. I accept and understand that if gum tissue shrinkage occurs, the denture (partial or full) could become difficult to wear, and could require the aid of denture adhesive in order to be worn.

_________ 10. **I accept and understand that the final opportunity to make a change in my denture (including shape, fit, size, placement or color) is during the "Teeth-In-Wax" visit**.

_________ 11. I have had the opportunity **to discuss** the Treatment Plan, and have had an opportunity **to ask questions**, and am fully satisfied with the answers received.

_________ 12. **If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.**

_________ 13. **I accept and understand that, as with any medical or dental procedure, there are no guarantees as to the longevity of the work performed. I also accept and understand that** *the Treatment Plan does not contain any warranty, and that any future adjustment(s) or replacement(s) will be at additional cost(s)*.

_________ 14. I accept and understand that I play a major role in the maintenance of my teeth and denture(s).

_________ 15. **I agree to maintain good oral hygiene and keep regular dental check-ups and cleaning appointments with Dr.___________________, at least every 6 months**.

_________ 16. **I accept and understand that, if these conditions are complied with, the** *ONLY* WARRANTY **provided under the Treatment Plain is:**

___________ a. **THIRTY (30) DAYS** – all adjustments following the placement of denture(s) will be at no charge (this does not include denture replacement).

___________ b. **AFTER THIRTY (30) DAYS** – patient pays 100% of current fee.

_________ 17. I understand that photographs may be taken of the procedures, and hereby give my consent to those photographs being taken, as well as my consent to before and after photographs being taken. I also understand and consent to those photographs being used for and in documentation, diagnosis and treatment planning.

Patient's Signature (or Parent/Guardian):_____________________________ **Date:** ____________

Patient's (or Parent/Guardian's) Identification: ____

Witness' Name:____________________ **Witness' Signature:**_________________ **Date:**________

Doctor's Signature: ____ **Date:** ____________________

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