Rosemeire Santos-Teachout, DDS, MS
Dansville Family Dental Care
191 Main St, Dansville, NY 14437

General Consent for Dental Treatment

Drugs and Medications: I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Teachout of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate equipment when using such drugs. Antibiotics may interfere with contraceptive medications and alternative methods of birth control are recommended while using antibiotics.

Fillings: I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely permanent and usually require periodic replacement.

Crowns, Bridges, Veneers: I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that may be prone to loosening and may need re-cementing. I will notify Dr. Teachout if this occurs so that a temporary restoration is maintained until the final restoration is delivered. I understand that any changes that I may desire in color, shape, size, etc, of a tooth must be made prior to final fabrication of the restoration. It is my responsibility to return within (1) month of tooth preparation for final cementation of the restoration.

Dentures: I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not permanent. Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require adjustments and one or more relines within several months.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification depending on unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand I may need further treatment by a specialist if complications arise during treatment and any costs thus incurred are my responsibility.

I have truthfully revealed all aspects of my health history. I understand that failure to cooperate fully with Dr. Teachout's recommendations may result in less than optimum results. I understand that it is my responsibility to have a thorough discussion with Dr. Teachout about my proposed treatment and have all my questions answered satisfactorily and to fully understand my proposed treatment before I proceed.

Patient Signature_____**Date**_____

Patient Name_____