Denture Consent Form

Patients Name_____
Last First Initial DOB

I here by authorize_____
Doctors name

And whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures:

I request and authorize (the Doctor named above) to do whatever he deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the alternatives, risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I fully realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. They may also impair speech, eating, and the appearance of your smile. 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 full or partial dentures while healing from surgery until the permanent ones are fabricated. I under stand that during this time I may require several adjustments and/or relines, to my temporary appliance.

I understand that the cost for the final denture and cost of any relines is additional to the above stated appliance unless agreed upon prior to start of procedure.

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_____