

**CONSENT FOR DENTAL TREATMENT  
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KINGWOOD TX 77339**

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
Date

**PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK FOR DOCTOR BEFORE INITIALING.**

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**1. APPOINTMENTS**

When scheduling an appointment, we are reserving chair time with the Dr., assistants and or dental hygienist. This time is reserved just for you and we appreciate prompt arrival as to not cause delays in your treatment. Any cancellation within 24 hours of your appointment time or failure to keep your appointment time will result in a \$75.00 charge to be applied to your account.

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**2. TREATMENT:**

I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Impacted tooth removal, Root Canals, Mini Implants, treatment of periodontal disease or other work deemed necessary.

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**3. 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 sever allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

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**4. RISKS OF DENTAL ANESTHESIA:**

I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, checks, tongue or associated facial structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

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**5. CROWNS, BRIDGES, INLAYS, AND ONLAYS:**

I understand that 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 are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

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**6. DENTURES:**

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as; shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time, and there is a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite comfortable for several days. Immediate dentures required frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

**Continued on Back**

7. RESTORATIVE:

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparations. 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 with additional fillings and/or crowns.

8. EXTRACTIONS:

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

9. PERIODONTAL DISEASE:

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

10. ROOT CANAL THERAPY:

I realize root canal therapy has a very high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These included; extensive decay making the tooth not restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success.

11. CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

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 dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

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Patient's or Guardian's Signature

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Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date