SAMPLE INFORMED CONSENT FORMS – APPROVED APRIL '99

Dentists have a legal and moral responsibility to act in the best interest of their patients. This includes proving advice to patients in an appropriate and understandable manner given the patient's capacity and respecting the patient's right to self determination of their health through consent. There are two types of consent that occur within the profession of dentistry:

IMPLIED CONSENT

- Occurs if the patient voluntarily comes to the office and agrees to allow someone else to do a specific procedure
- Occurs in emergency situations where a delay could be hazardous to the patient's life
- Examples are simple examinations or non invasive procedures. The patient can object at any time and has some understanding of what is going on.

EXPRESSED OR INFORMED CONSENT

- Is consent given after disclosure of all information reasonable under the circumstances, which allows a competent person to make an intelligent decision on their future treatment. The level of disclosure by a dentist to a patient is measured by the patient's informational needs. Since different patients have varying needs for information, the scope of disclosure will vary even among patients with the same conditions.
- Examples are procedures beyond a simple examination such as oral surgery, extractions, bridge work, orthodontics, implants, dentures, sedation, major or minor surgery involving entry into the body, non-surgical procedures that may cause change or harm to the body and all experimental procedures.

LEGAL CONSIDERATIONS

- Although a patient may agree to sign a consent form stating they have no questions, and are prepared to submit to the treatment whatever the risks may be without any explanatory discussion, dentists must exercise cautious discretion in accepting such waivers.
- Consent forms should be developed for specific situations. Blanket consent forms will not be considered valid in court. *For this reason the College cannot endorse or recommend any particular form*.
- Consent forms do not absolve a dentist from liability when the dentist feels it is against his/her better judgement but the patient is insisting that is the way they want it done. A consent form by itself is insufficient to ensure informed consent has been given.
- Further documentation beyond a consent/disclaimer form is required when patients' choose not to accept or receive treatment. A disclaimer form by itself is more useful when patients refuse to have x-rays taken than when they refuse to accept antibiotic prophylactics. *The final responsibility for meeting dental professional standards and ultimately patient health lies with the dentist*.

In order to meet the moral, ethical and legal obligations of consent, the College suggests that the following information be provided to the patient. ***The College cannot endorse or recommend any particular form because each one should be unique unto itself and meet the patient's needs***. Oral and written consent are legally acceptable, however, oral consent should be confirmed in writing and documented it the patient's chart where risks are significant.

ANY CONSENT FORM SHOULD INCLUDE THE FOLLOWING INFORMATION

- patients name, address and age
- general description of the condition
- diagnosis or problem noted
- if there is uncertainty about diagnosis mention this uncertainty, the reason for it and what is being considered
- nature and purpose of proposed treatment
- risks and benefits of proposed treatment
- realistic outcome of treatment (aesthetic, functional or limitations)
- alternatives available, explained and offered
- patient must be given the opportunity to ask questions
- consequences of leaving the ailment untreated or their refusal for treatment
- estimated costs of proposed treatment
- document must be signed by the patient and witnessed

INFORMED CONSENT FOR DENTAL PROCEDURES

(Please initial each paragraph after reading)

I hereby authorize Dr. _____ and/or employees who are working with him/her to perform the following dental treatment/procedures/surgery upon (myself/guardian) to permit:

___preventive (polishing, scaling) treatment___fluoride treatment

___restorations (fillings) ___veneer/bleaching

___periodontal services (root planing) ___other(_____)

as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand the recommendations detailed in my chart and with full knowledge of alternative treatment procedures and the treatment plan chosen by myself is that of_____

In requesting this treatment choice, I recognize that the dentist accepts my right to choose the treatment plan of my choice following my consideration to the alternate treatment plans provided to me.

I fully understand that:

- I require a dentist's evaluation at least once a year, prior to receiving dental treatment by any allied dental personnel (hygiene care) to prevent, minimize and diagnose conditions which could result in complications associated with dental treatment. I recognize that the dentist has the best training and expertise to evaluate those risks.
- The dentist has not, nor can guarantee that the procedure/treatment will last for any specific period. No refund will be given in the event of failure.
- I must follow the entire course of treatment including personal oral hygiene (daily flossing, brushing, post-treatment instructions, etc.) or the anticipated outcome of this procedure/treatment could be affected
- I have read and understand the reading material provide to me (if any, please list)
  ___restorative materials ___fact sheets_____

If I decline Treatment

The doctor has advised me that if this condition persists without any treatment, my present condition will probably worsen with time and the risks to my health may include, but are not limited to the following: swelling; pain; infection; cyst formation; periodontal (gum) disease; dental caries; malocclusion; pathologic fracture of jaw; premature loss of teeth; and/or premature loss of bone.

Fees for Services Rendered

It is further accepted the financial office policy(s) in this office "that dental fees in this office are based on the nature and complexity of the dental procedure" and that I am responsible for any costs incurred for services rendered in this office, regardless of any third party dental coverage which I may have.

IF YOU HAVE ANY QUESTIONS CONCERNIG THE RECOMMENDED TREATMENT, ALTERNATIVES, BENEFITS, LIMITATIONS, POSSIBLE COMPLICATIONS OR ANY OTHER INFORMATION, PLEASE ASK BEFORE SIGNING THIS CONSENT FORM.

Patient Signature_____Witness_____

Address_____Date_____

Potential Risks

The dentist has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risk include, but are not limited to: (check item applicable)

1. pain, swelling or poor healing that may require home recuperation
2. damage to and possible loss of other teeth or restorations
3. infection, abscess or nasal problems requiring additional treatment
4. bleeding may be prolonged
5. loss of bone
6. fracture of the jaw
7. injury to nerves at treatment site which may cause pain, numbness or tingling of lips, chin, face, mouth and tongue or loss of ability to taste (usually temporary but may be permanent)
8. stretching on the corners of the mouth with resultant cracking and bruising
9. restricted mouth opening for several days or weeks
10. decision to leave a small piece of root in the jaw when its removal would require extensive surgery
11. swelling/bruising of the IV site (please contact the office if this persists)
12. I am aware that in any procedure complications can develop which could leave me in a worse state that when it was begun
13. Other

Fees for Services Rendered

It is further accepted the financial office policy(s) in this office "that dental fees in this office are based on the nature and the complexity of the dental procedure" and that I am responsible for ay costs incurred for services rendered in this office, regardless of any third party dental coverage which I may have.

IF YOU HAVE ANY QUESTIONS CONCERNIG THE RECOMMENDED TREATMENT, ALTERNATIVES, BENEFITS, LIMITATIONS, POSSIBLE COMPLICATIONS OR ANY OTHER INFORMATION, PLEASE ASK BEFORE SIGNING THIS CONSENT FORM.

Patient Signature_____Witness_____

Address_____Date_____

INFORMED CONSENT FOR ORAL SURGERY

(Please initial each paragraph after reading)

I hereby authorize Dr._____ and /or employees who are working with him/her to perform the following dental treatment/procedures/surgery upon myself, to permit_____ as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand the recommendations detailed in my chart and with full knowledge of alternative treatment procedures, the treatment plan chosen by myself is that of_____

In requesting this treatment choice, I recognize that he/she accepts my right to choose the treatment plan of my choice following my consideration to the alternative treatment plans provided to me.

I understand that certain medical conditions may contraindicate this treatment and that the medical history I have provided to the dentist is accurate and up–to-date.

Realistic Benefits and Outcomes:

The dentist's prognosis for this disease given the recommended treatment is:
(poor/fair/good/very good/excellent)
With the recommended treatment/procedure, anticipated benefits may include but are not limited to: aesthetically:_____
functionally:_____
limitations by or to: _____

I fully understand that the dentist has not, nor can guarantee that the procedure/treatment will last for any specific period. No refund will be given in the event of failure.

I understand I must follow the entire course of treatment including personal oral hygiene (daily flossing, brushing, post-treatment instructions, etc.) or the anticipated outcomes of this procedure/treatment could be affected.

If I decline this treatment

The doctor has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen with time and the risk to my health may include, but are not limited o the following: swelling: pain: infection: cyst formation: periodontal (gum) disease: dental caries: malocclusion: pathologic fracture of the jaw: premature loss of teeth: and /or premature loss of bone.

Alternative Methods of Treatment

I have been informed of possible alternative methods of treatment which are:
_____no treatment other _____

INFORMED CONSENT FOR CROWN PROCEDURES

(Please initial each paragraph after reading)

I hereby authorize Dr. _____ and/or any employees who are working with him/her to perform the following dental treatment/procedures/dental surgery upon myself, to permit _____as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand the recommendations detailed in my chart and with full knowledge of alternative treatment procedures the treatment plan chosen by myself is that of:

In requesting this treatment choice, I recognize that he/she accepts my right to choose the treatment plan of my choice following my consideration to the alternate treatment plan(s) provided to me.

I understand that the purpose of the procedure is to place a crown over the ____tooth for the following reason(s):
____I have one/several teeth missing and my remaining teeth and gums are strong and healthy
____to alter the occlusion by_____.

I understand that certain medical conditions may contraindicate this procedure and that the medical history I have provided to the dentist is accurate and up-to-date.

Costs and Nature of Materials to be Used

- This procedure will use a:____porcelain,____porcelain fused to metal, or____ all metal (gold or metal alloy) type of crown.
- It is manufactured as a dental laboratory and the costs for this product are (are not) included as part of the dentist's service fees.

Realistic Benefits and Outcomes

The dentist's prognosis for this oral disease given the recommended treatment is: (poor/fair/good/very good/ excellent) with the recommended treatment/procedure, anticipated benefits may include but are not limited to:

aesthetically:_____

functionally:_____

longevity:_____

limitations by or to:_____

anticipated length of adjustment period:_____

will require a minimum of _____dental appointments

I fully understand that the dentist has not, nor can guarantee the procedure/treatment will last for any specific period. No refund will be given in the event of failure.

I understand that crowns and bridges are not as strong as natural teeth and extra care is needed to avoid undue trauma to them such as wearing mouth-guards during sports. Furthermore, I must follow the entire course of treatment including personal hygiene (daily flossing, brushing, plaque removal, post-treatment instructions, etc.) or the anticipated outcomes of this procedure/treatment could be affected.

If I decline Treatment

The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably_____ and the risk to my health may include, but are not limited to the following: decreased ability to chew properly: inability to smile confidently: negative impact on your self esteem, poorer eating habits which are linked to heart disease and obesity, further tooth loss, bone loss, other teeth shifting, tooth pain when eating, TMJ pain, digestive problems, other
_____

Alternative Methods of Treatment

I have been informed of possible alternative methods of treatment which are:

____no treatment at all _____fixed bridge(fixed partial denture)
____no crown _____removable partial denture
____other

The dentist has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such risks include, but are not limited to: (check item applicable)

1. symptoms may initially be exacerbated by the treatment mentioned
2. risk of eventual tooth fracture since it is more brittle than a natural tooth
3. constant holding crown in place may eventually loosen
4. the tooth can get sick again from new decay, bone loss or a broken filling
5. possible infection which would necessitate its removal with the possibility of future replacement alter adequate healing. (there will be a charge made for replacement procedures)
6. complications which can develop which could leave me in a worse state than when it was began
7. other _____

Fees for Services Rendered

It is further accepted the financial office policy(s) in this office "that the dental fees in this office are based on the nature and complexity of the dental procedure" and that I am responsible for any costs incurred for services rendered in this office, regardless of any third party dental coverage which I may have.

IF YOU HAVE ANY QUESTIONS CONCERNING THE RECOMMENDED TREATMENT, ALTERNATIVES, BENEFITS LIMITIATIONS, POSSIBLE COMPLICATIONS OR ANY OTHER INFORMATION, PLEASE ASK BEFOR SIGNING THIS CONSENT FORM.

PATIENT'S NAME_____DATE_____

ADDRESS:_____WITNESS_____

INFORMED CONSENT FOR IMPLANTS

(Please initial each paragraph after reading)

I hereby authorize Dr._____ and/or employees who are working with him/her to perform the following dental treatment/procedures/surgery upon myself, to permit_____
As previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand the recommendations detailed in my chart and with full knowledge of alternative treatment procedures, the treatment plan chosen by myself is that of_____

In requesting this treatment choice, I recognize that he/she accepts my right to choose the treatment plan of my choice following my consideration to the alternative treatment plans provided to me.

I understand that the _____ type of implants is recommended and that I agree to the procedure for the following reason(s):

- replacement of missing teeth without using remaining teeth as abutments
- poor denture retention due to bone atrophy
- hyperactive gag reflex
- unrealistic removable prosthetic expectation
- medically unable or willing to tolerate bone grafting or bone reshaping
- poor quality tissue
- psychologically will not tolerate a denture

I understand that certain medical conditions (e.g. local radiation therapy, diabetes and steroid medication may contraindicate implant surgery) and that the medical history I have provided to the dentist is accurate and up-to-date.

Realistic Benefits and Outcomes

The dentist's prognosis for this oral disease given the recommended treatment is: (poor/fair/good/very good/ excellent) with the recommended treatment/procedure, anticipated benefits may include but are not limited to:
aesthetically:_____

functionally:_____

longevity:_____

limitations by or to:_____

anticipated length of adjustment period:_____

I fully understand that the dentist has not, nor can guarantee the procedure/treatment will last for any specific period. No refund will be given in the event of failure.

I fully understand that the dentist has not, nor can guarantee the procedure/treatment will last for any specific period. No refund will be given in the event of failure.

If I decline Treatment

The doctor has advised me that if this condition persists without treatment or surgery, my present condition will _____ and the risk to my health may include, but are not limited to, the following_____.

Alternative Methods of Treatment

I have been informed of possible alternative methods of treatment which are:

____no treatment at all
____conventional crown and bridge work
____other implant system
_____grafting of bone or soft tissue
_____removable prosthesis
_____other

Potential Risks

The dentist has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risk include, but are not limited to: (check item applicable)

1. pain, swelling or poor healing that may require home recuperation
2. damage to and possible loss of other teeth or restorations
3. infection, abscess or nasal problems requiring additional treatment
4. bleeding may be prolonged
5. loss of bone
6. fracture of the jaw
7. injury to nerves near treatment site which may or cause altered sensation pain, numbness or tingling of lips, chin, face, mouth and tongue or loss of ability to taste (usually temporary but may be permanent)
8. accidental opening and infection of the normal sinus cavity located above upper teeth.
9. possible rejection of the implant which would necessitate is removal with the possibility of future replacement after adequate healing (there will be a charge made for replacement procedures)
10. stretching of the corners of the mouth with resultant cracking and bruising
11. restricted mouth opening for several days or weeks
12. I am aware that in any procedure complications can develop which could leave me in a worse state that when it was begun
13. Other

Fees for Services Rendered

It is further accepted the financial office policy(s) in this office "that dental fees in this office are based on the nature and the complexity of the dental procedure" and that I am responsible for ay costs incurred for services rendered in this office, regardless of any third party dental coverage which I may have.

IF YOU HAVE ANY QUESTIONS CONCERNIG THE RECOMMENDED TREATMENT, ALTERNATIVES, BENEFITS, LIMITATIONS, POSSIBLE COMPLICATIONS OR ANY OTHER INFORMATION, PLEASE ASK BEFORE SIGNING THIS CONSENT FORM.

Patient Signature_____Witness_____

Address_____Date_____

INFORMED CONSENT FOR DENTURES PROCEDURES

(Please initial each paragraph after reading)

I hereby authorize Dr._____ and /or employees who are working with him/her to perform the following dental treatment/procedures/surgery upon myself, to permit_____ As previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand the recommendations detailed in my chart and with full knowledge of alternative treatment procedures, the treatment plan chosen by myself is that of_____

In requesting this treatment choice, I recognize that he/she accepts my right to choose the treatment plan of my choice following my consideration to the alternative treatment plans provided to me.

I understand that the purpose of the procedure is to place a prosthesis for the following reasons:

____ I have one/several missing teeth and my remaining teeth and gums are strong and healthy
____ I have several missing teeth and have lost some gum tissue to gum disease. The remaining teeth are weak.
____ I have severe gum disease and have lost many teeth
____ this procedure will require the anchor tooth or teeth to be crowned to provide extra strength to the anchor tooth since this tooth/teeth are weak.

I understand that certain medical conditions may contraindicate this procedure and that the medical history I have provided to the dentist is accurate and up-to-date.

Costs and Nature of Materials to be Used

The prosthesis will be made of:
_____ acrylic or ____metal (gold or metal alloy) frame supported with an acrylic portion. It is manufactured at a dental laboratory and the costs for this produce are (are not) included as part of the dentist’s service fees.

Alternative Methods of Treatment

I have been informed of possible alternative methods of treatment which are:

____no treatment at all _____fixed bridge (fixed partial denture)
____no crown _____removable partial denture
____ complete dentures _____other

Realistic Benefits and Outcomes

- The dentist's prognosis for this oral disease given the recommended treatment is: (poor/fair/good/very good/excellent)
- With the recommended treatment procedure, anticipated benefits may include but are not limited to:

aesthetically:_____

functionally:_____

longevity:_____

limitations by or to:_____

anticipated length of adjustment period:_____

will require a minimum of ____dental appointments and _____laboratory appointments
will require a minimum of ____relining or remaking appointments. Additional charges will occur for subsequent appointments.

I fully understand that secure, properly fitting dentures cannot duplicate the effectiveness and ability to chew as my natural teeth. On average, dentures will only provide 15% of the pressure available with real teeth.

I fully understand that the dentist has not, nor can guarantee that procedure/treatment will last for any specific period. No refund will be given in the event of failure.

I understand that crowns and bridges are not as strong as natural teeth and extra care is needed to avoid undue trauma to them such as wearing mouth-guards during sports.

Furthermore, I must follow the entire course of treatment including personal oral hygiene (daily flossing, brushing, plaque removal, post-treatment instructions, etc.) or the anticipated outcomes or longevity of these procedure/treatment or prosthesis could be affected.

If I decline treatment

The doctor has advised me that if this condition persists without treatment of surgery, my present oral condition will probably worsen and the risk to my health may include, but are not limited to, the following: decreased ability to chew properly: inability to smile confidently: negative impact on self-esteem, poorer eating habits which are linked to heart disease and obesity, further tooth loss, bone loss, other teeth shifting. TMJ pain, other_____