Dentures, Complete or Partial

Patient Name: ____

Email: ____ Phone Number: ___________________________

1.) **WORK TO BE DONE:** ____
  - I understand that I am having the following work done:

2.) **DRUGS AND MEDICATIONS**
  - I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting and/or anaphylactic shock (severe allergic reaction)

3.) **CHANGES IN TREATMENT PLAN**
  - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary

I 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. I realize the final opportunity to make changes in my new dentures (including shape, size, fit, placement and color) will be the “Wax Try-In” visit. I understand that I may need adjustments after the appliance is delivered to me.

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 “Wax Try-in” visit. I understand that once I agree to have the denture finished at the “Wax Try-in” visit, the design and appearance of the denture are “locked in”, and any changes after this time will incur additional costs that could be significant and may require the denture to be remade at my expense (full cost of new denture). Adjustments are often needed with new dentures, and will be included in the original fee for 30 days following delivery of the dentures, after which our regular adjustment fee will be incurred.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment and all questions have been answered to my satisfaction.

______________________________	______________________________	______________
Signature of Patient, Parent, Guardian or Personal Representative	Printed Name of Patient, Parent, Guardian or Personal Representative:	Date