Denture Consent Form

Patient information	
Name:	Date:
Address:	
Phone number:	Email:

Description of treatment

This consent form pertains to the proposed treatment involving the fitting, adjustment, repair, or replacement of dentures, including partial or full dentures. This treatment is intended to restore oral function, improve aesthetics, and address any dental issues related to missing or damaged teeth.

Potential risks and complications

By signing this form, I acknowledge that i have been informed of and understand the potential risks and complications associated with denture treatment, which may include:

- **Tissue irritation or soreness** due to improper fit or initial adjustment period.
- **Difficulty with speech or chewing** as part of the adaptation process.
- **Allergic reactions** to materials used in the dentures.
- **Substantial harm** to oral tissues, including gum irritation or bone resorption over time.
- **Loosening or instability** of the dentures, requiring adjustments or relining.
- **Complications from related procedures**, such as extractions or dental implants, if applicable.

Benefits of treatment

The benefits of denture treatment include but are not limited to:

- Restoration of chewing ability.
- Improved speech clarity.
- Enhanced aesthetic appearance of the smile.
- Preservation of facial structure by supporting the jaw and soft tissues.

Alternative treatment options

I have been informed of the following alternatives to the proposed treatment:

- **Partial dentures** as an alternative to full dentures.
- **Dental implants** to replace individual or multiple missing teeth.
- **Retaining natural teeth** if viable and appropriate.
- **No treatment**, understanding the potential consequences of this decision, including further tooth loss or changes in facial structure.

Financial information

I have been provided with a detailed estimate of the costs associated with the proposed treatment. I understand the financial obligations and the payment options available to me.

Patient acknowledgment

I, _____[Patient's full name]_____, confirm that:

1. I have received a clear and thorough explanation of the proposed treatment, its potential risks, benefits, and alternatives.
2. I have had the opportunity to ask questions and have received satisfactory answers.
3. I fully understand the nature of the proposed treatment and its potential outcomes.
4. I voluntarily consent to proceed with the denture treatment as discussed.

Patient signature:	Date:

Dentist declaration

I, _____[Dentist's full name]_____, confirm that:

1. I have provided a clear and thorough explanation of the proposed treatment to the patient.
2. I have answered all questions to the best of my ability and ensured the patient’s understanding.
3. I have documented this discussion and the patient’s consent appropriately.

Dentist signature:	Date: