Discussion and Informed Consent for Denture(s)

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment: _____

Facts for Consideration

Candidates for prosthetic devices have lost some or all of their teeth. Dentures are designed to replace teeth of an upper or lower jaw. The following types of removable dentures have been discussed:

1. An immediate denture is placed at the time any remaining teeth are extracted. To make this possible, measurements and models are taken during the preliminary visit. However, bones and gums can shrink over time, especially during the healing period in the first six months after any extraction of teeth. When gums shrink, immediate dentures may require rebasing or relining to fit properly. The immediate denture is often temporary and will require replacement.

2. A conventional full denture is placed in the mouth after all of the teeth have been removed and any extraction sites have healed, usually six to eight weeks after typical extractions.

3. A partial denture is usually composed of framework, artificial teeth and acrylic material. It fills in the spaces created by missing teeth and prevents other remaining teeth from shifting.

4. An overdenture is usually supported by a small number of remaining natural teeth or implants. The denture fits "over" the teeth or implants. Natural teeth must be prepared (reshaped) to fit into the overdenture and provide stability and support for the denture.

Option(s) Chosen: _____

Patient's initials required

_____ I understand the stability and retention of the denture(s) depends on many factors, including the attachment and fit of the denture(s) to natural teeth, implants (if any), the amount and type of bone, gum tissue and saliva, as well as my ability in placing and removing the denture(s).

_____ When using natural teeth as support, I understand my dentist may anesthetize (numb) my teeth and the gum tissue around the teeth. The teeth acting as support may be filed down along the chewing surface and sides to make room for the denture(s).

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. This can occasionally be an indication of a further problem. I must notify my dentist if this or other concerns arise. This problem may require other treatment.

_____ I understand there may be gum soreness or discomfort under the denture(s). This can be relieved by the dentist with adjustments and tissue treatment. It may take several appointments before the denture(s) fit comfortably.

_____ I understand the new denture(s) may feel awkward for a few weeks until I become accustomed to them and the denture(s) may feel loose while my cheek muscles and tongue learn to keep them in place.

_____ I understand my dentist will make every attempt to create a natural appearance for the denture(s); however, it may not be possible for the denture(s) to support my lip and facial contours perfectly or as my natural teeth had done.

_____ I understand eating with the denture(s) will require practice. My dentist has recommended I start with soft foods cut into small pieces and chew slowly, using both sides of my mouth at the same time to prevent the denture(s) from tipping. I understand I need to be cautious when eating chewy, hot or hard foods (for example: apples, popcorn, raisins, candy).

_____ I understand that pronouncing certain words may take practice. I can do this by reading aloud and repeating troublesome words. Sometimes the denture(s) will slip when I laugh, cough or smile. I can reposition the denture(s) by gently biting down and swallowing. If a speaking problem persists, I will call my dentist for consultation.

_____ Similar to natural teeth, I understand that my denture(s) require(s) daily brushing to remove food deposits and plaque. My dentist has explained to me how best to care for my denture(s) and which products to use. I have to brush my gums, tongue and palate with a soft bristled brush before wearing my denture(s). If I do not properly clean or care for my denture(s), they may stain, develop odor and affect the way food tastes.

_____ I understand that any adjustments or changes I make to my denture(s) can compromise the denture(s) and cause gum and cheek irritation and sores. If my denture(s) become loose, chip, crack or break, I will contact my dentist immediately. Glue purchased over the counter to repair a broken denture often contains harmful chemicals and should not be used on dentures. Adjusting my denture(s) on my own is not advised and may result in permanent changes to the denture(s) that will affect their fit and function. This may also result in the need to remake the denture, which I understand will be at my own expense.

_____ I understand that I am required to keep regular care appointments with my dentist to maintain good oral health and ensure my denture(s) retain their proper fit and function. Failure to do so may result in injury or damage to my oral health including gums and jawbone.

_____ I understand that every reasonable effort will be made to ensure the success of my treatment but that success cannot be guaranteed.

Benefits of Dentures, Not Limited to the Following:

_____ I understand that a reasonable aesthetic appearance may be achieved.

_____ With my new denture(s), I understand my function and ability to eat will usually improve as opposed to being edentulous (without teeth).

Risks of Dentures, Not Limited to the Following:

_____ I understand that there are potential problems such as periodontal (gum) disease, porcelain fractures, occlusal (bite) changes, stains and color changes, gum recession, food impaction, decay, excessive wear due to grinding and bruxing or temporomandibular joint dysfunction (TMD).

_____ I understand that dentures may have characteristics and potential problems such as odor, chipping and wear, stability and retention problems, changes in facial and lip appearance and adaptation of the tongue and lips for proper speech. Periodic relines may be required as gum and bone may change over time, oral sensations may change and good oral hygiene is imperative.

_____ I understand ill-fitting dentures can cause constant irritation over a long period of time and may contribute to the development of sores. Failure to wear my denture(s) over a long period of time may affect the fit of the denture(s). My denture(s) may need to be relined or replaced. If my denture(s) begin to feel loose or cause pronounced discomfort, I will contact my dentist.

_____ I understand a numb lip may occur from the pressure of the removable denture(s). This problem requires selective adjustment and in rare cases a nerve might need surgical repositioning.

_____ I understand that the edge of the denture(s) usually rests on the gum line, which is in an area prone to gum irritation, infection or decay. Proper hygiene at home, a healthy diet and regular professional cleanings are some preventative measures essential to control these problems.

Consequences if No Treatment Is Administered, Not Limited to the Following:

_____ I understand that I can choose to do nothing and my present complaints will continue and may worsen. Subsequent choices for dentition repair may become more difficult, expensive or not feasible.

_____ I understand that if I do not replace missing teeth, I risk compromised aesthetics and possible drift of adjacent and/or opposing teeth into the space(s) with the resultant collapse of the arch integrity. This could also create or exacerbate a temporomandibular joint problem.

Treatment Process:

_____ I understand the following timeline represents an estimate of the treatment proposed by my dentist. It is important that I keep appointments within close succession of the estimated timeline or I risk compromising the entire treatment plan.

Exam, shade, mold selection and impression	Est. date completed: _____
Mouth preparation, surgical adjustment	Est. date completed: _____
Multiple impressions, custom trays	Est. date completed: _____
Try-in wax adjustment	Est. date completed: _____
Adjustment and delivery	Est. date completed: _____

Alternatives to Dentures, Not Limited to the Following:

_____ I understand that depending on the reason I am a candidate for dentures, alternatives may exist including the use of dental implants to support the denture. I have asked my dentist about the alternatives and their respective expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits and costs.

Alternatives Discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the condition(s) listed above. I have had my questions answered to my satisfaction.

Check the boxes below that apply to you:

Consent

□ I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.

□ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

□ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr._____ to do whatever he/she deems necessary and advisable under the circumstances.

□ I consent to have the above-mentioned treatment.

□ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

□ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date