

PARTIAL DENTURE INFORMED CONSENT

The associated treatment plan indicates the teeth to be replaced using a partial denture. See teeth numbers and visual tooth chart on treatment plan.

PURPOSE OF THE TREATMENT:

This procedure is deemed necessary for any of the following reasons:

- Present Partial is Unsuitable, Ill-fitting, Old, Unsightly etc.
- Initial Replacement of Many Missing Tooth/Teeth
- I would like an aesthetic-type denture (no metal) to improve my smile
- Other _____

DENTURES USUALLY REQUIRE THREE (3) APPOINTMENTS.

The **1st** appointment will require 60 minutes of your time.

It consists of :

Final Impressions (your existing denture(s) may be used in this process)
Jaw Relation Records and Measurements
Tooth Shape and Shade Selection

The **2nd** appointment will require 60 minutes of your time.

It consists of :

Partial Denture Try-in

[This appointment may be scheduled at the laboratory so that the denture technician may join us and make any adjustments immediately]

The **3rd** appointment will require 30 minutes of your time.

It consists of:

Delivery of Denture(s) and Adjustments

Subsequent appointments may be made for adjustments as required.

Adjustments are completed at no additional charge for THREE MONTHS following the delivery date.

BENEFITS OF THE TREATMENT:

The replacement of teeth with partial dentures will help patients regain the ability to chew foods, and distribute chewing forces, properly. Partial dentures may replace lost supporting structures and therefore, will improve facial form and general appearance as well.

RISKS OF THE TREATMENT:

There are rare instances of allergic responses to impression material, tissue conditioning material, or to the material the dentures are made of. These are reversible and disappear upon removal of the offending substance. Breathing in or swallowing of the impression material is extremely rare.

ALTERNATIVES TO THE TREATMENT:

If the density, height, and width of the jaw bone is sufficient, implants may be a feasible alternative to a partial denture.

If teeth on either side of the spaces are healthy, many different types of bridges may be a more permanent alternative.

No treatment is always an option.

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment. I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material. I have been given the opportunity to ask questions.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment.

I have reviewed the Office Financial Policy and agree to comply with it. I have received the treatment plan(s) for the procedure(s). The fees (Professional and Laboratory) have been outlined & clearly explained to me and I agree to pay the fees. I have been given the opportunity to ask any further questions and I am satisfied with the answers given. I have no further questions.

Dated at London, Ontario, _____

PRINTED: _____
Name of Patient

SIGNED: _____
Signature of Patient

SIGNED: _____
Parent, Guardian or Nearest Kin if patient
is under the age of 18