Crown Dental Studio

IMMEDIATE DENTURE CONSENT FORM

WHAT TO EXPECT:

Going from natural teeth to a denture is a big adjustment for any patient. The patient's ability to chew food decreases about 90%. Taste of food and often speech may be altered at first. In general, an upper denture is easier to adjust to than a lower denture. The amount of stability of a denture depends on several things and not all people adapt to dentures as well as others. We will do everything in our power to help you adjust to your new dentures, however, the patient must realize that dentures are a satisfactory replacement for having no teeth at all but they very rarely function as well as natural teeth.

For 3-5 weeks after the delivery of your dentures, you may require follow up appointments to adjust the denture as your mouth heals and the dentures settle in. Because the lab have to estimate the shape of the ridge when extracting and immediately placing dentures, it is not possible to get an accurate a fit as you would with conventional dentures. It is normal for the denture to loosen further as your mouth heals. The ridges that held your teeth in before will shrink and change shape. Most of your changes will occur in the first three months and then the ridge will begin to stabilize.

Therefore, you must accept the fit will not be wholly accurate, and there will be a degree of looseness of the denture. This will worsen for next few months.

DIFFICULTIES AND PROBLEMS WITH WEARING DENTURES

The difficulties and problems associated with wearing dentures have been presented to me, along with my treatment plan. These issues include, but are not limited to:

- Difficulties with speaking and/or eating
- Food under dentures
- Functional problems
- Loose dentures
- Lack of retention
- Need for adhesives
- Feeling of fullness
- Increased saliva production
- Effect(s) of poor ridge shape and form.
- The possible need for future relines and remakes of either immediate or conventional dentures (each treatment will carry a further fee)

Crown Dental Studio

I confirm that I have been provided with verbal/written information about immediate dentures and understand:

- Immediate dentures are transitional dentures and must be relined or remade, usually about three to nine months following insertion.
- Fees for any possible relines or remakes of immediate dentures are NOT INCLUDED in the immediate denture fee.
- A complete lower immediate denture, or partial denture where there are no teeth on either side of the mouth, will be particularly loose. In such cases, the patient my struggle with a denture.
- Some patients will never tolerate a denture.
- Ideally, a complete denture is best supported by implants.
- Bone resorption will continue throughout my lifetime making subsequent denture construction more difficult, less satisfying, and less comfortable for me than my previous denture experience.

I HAVE BEEN FULLY INFORMED OF THE FEES AND PROBLEMS ASSOCIATED WITH IMMEDIATE AND COMPLETE DENTURES, THE ALTERNATIVE TREATMENTS AVAILABLE, AND THE NECESSITY FOR FOLLOW-UP CARE. I HAVE HAD AN OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE IN CONNECTION WITH THE TREATMENT AND FEES AND TO DISCUSS MY CONCERNS WITH CROWN DENTAL AND THEIR STAFF. AFTER THOROUGH CONSIDERATION, I CONSENT TO DENTURE FABRICATION AS PRESENTED TO ME DURING THE CONSULTATION AND IN THE TREATMENT PLAN PRESENTATION. BY SIGNING THIS DOCUMENT, I AUTHORIZE CROWN DENTAL AND /OR HIS/HER ASSOCIATES TO RENDER ANY SERVICES DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF MY DENTAL CONDITION, INCLUDING THE PRESCRIBING AND ADMINISTRATION OF ANY MEDICALLY NECESSARY ANESTHETIC AGENTS AND/OR MEDICATIONS. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Crown Dental Studio

I HEREBY CONSENT AND AGREE TO RECEIVE THE FOLLOWING ALTERNATE TREATMENTS IN THE EVENT OF THE DESIRED RESULTS NOT BEING ACHIEVED:

1. ____
____
____

2. ____
____
____

3. ____
____
____

4. ____
____
____

5. ____
____
____

PATIENT PARTICULARS:

FULL LEGAL NAME: ___________________________________

IDENTITY NUMBER: ___________________________________

ADDRESS: ____
____
____

CONTACT NUMBER: _____________________________________

Crown Dental Studio

EMAIL ADDRESS: ____

Accepted and Signed at _________________ on this _____ day of _________________ 20______

in the presence of the undersigned witnesses

____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

Witnesses:

1. _________________________________
   NAME:
   CONTACT NUMBER:
2. _________________________________
   NAME:
   CONTACT NUMBER: