



Informed Consent for Removable Prosthodontics Dentures (Full, Partial, Immediate)

I have been made aware of the condition of my mouth requiring fabrication of the following removable denture(s):

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Full | <input type="checkbox"/> Full |
| <input type="checkbox"/> Partial | <input type="checkbox"/> Partial |
| <input type="checkbox"/> Immediate | <input type="checkbox"/> Immediate |

Procedure:

A denture is a fabricated prosthesis (made of acrylic, or a combination of metal and acrylic) to replace some or all of my missing teeth. The procedure typically requires several appointments during fabrication and adjustments, and may take several weeks to complete.

Alternative Treatment Options:

I understand the alternatives to denture(s) may include restorative treatment (periodontal therapy, endodontic (root canal) treatment, crowns, bridges, implants, etc.) or no treatment at this time. I realize that postponement of treatment may result in future pain, infection, bone loss, and/or loss of the tooth/teeth.

Risks and Limitations:

I understand that dentures are not natural teeth and may not function like natural teeth. Becoming accustomed to wearing, functioning, and speaking with dentures takes time, effort, and commitment on behalf of you the patient. Dentures may, at times, feel loose or become loose due to changes in the supporting structures of the jaw(s) and remaining teeth, if any. I accept and understand that denture (partial or full) treatment results are subjective; thus, the outcome of my Treatment Plan may not completely meet my expectations. I accept and understand that dentures (full or partial) made within six (6) months of tooth/teeth extraction(s) may become ill-fitting as the gum tissues around the extraction site(s) shrink, which may require the denture to be relined or replaced at an additional cost.

I accept and understand that if gum tissue shrinkage occurs, the denture (partial or full) could become difficult to wear, and could require the aid of denture adhesive in order to be worn. I understand that my dentures, implants and/or natural teeth (specifically with partial dentures) still require regular brushing, flossing and continued care. Dentures (full overdentures or partial dentures) do not protect my teeth, supporting bone and gum tissue from decay or periodontal disease. **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 90 days following delivery of the dentures, after which our regular adjustment fee will be incurred.

Risks and Limitations of this, and any, denture are as follows:

- Looseness of denture
- Soreness of gum tissues
- Breakage or wear of denture
- Difficulty wearing denture
- Shrinkage of gum and bone
- Change in speech or appearance
- Need for reline, readjustment
- Use of denture adhesive
- Food particles slipping under denture or replacement (additional costs)

Informed Consent:

I understand and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment and have received answers to my satisfaction. I have been informed of and am fully aware of all alternative treatment options. I voluntarily assume any and all possible risks, including the risk of substantial harm, which may be associated with any phase of this treatment in hopes of obtaining the desired result. I understand that the practice of dentistry is not an exact science and no procedure is 100% successful. Dr. Zaugg and his team will take every action to provide the highest level of care, but have made no guarantees of a successful outcome. If a problem develops, it is my responsibility to notify Dr. Zaugg or one of his team members. The fees for proposed services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. Zaugg and his team members in rendering any services they deem necessary or advisable to treat my dental condition(s).

Patient Name (Printed)

Date

Patient or Legal Guardian Signature

Doctor/ Staff Signature

Date