

## **DENTURE PREPARATION AND PLACEMENT OF FULL OR PARTIAL DENTURES**

Patient  
Initials

- \_\_\_\_\_ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.
- \_\_\_\_\_ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.

### **My dentist has recommended a removable:**

- Full or complete denture to replace my:
- Upper       Lower       Both upper and lower missing teeth.
- Partial denture for teeth \_\_\_\_\_ as part of my dental treatment plan.

\_\_\_\_\_ I understand and accept that a denture should not be expected to perform as well as my natural teeth, but with proper care, years of satisfactory service are possible.

### **For All Dentures**

Your denture will be made specifically for you, and Dr. \_\_\_\_\_ will make every effort to work with the dental laboratory to match your natural teeth. There are limitations to creating a denture that is a perfect match due to color, extent of staining, shape, and/or placement of your original teeth. There are no guarantees that an exact match is possible. Therefore, it is important for you to be an active partner during the fitting process and follow all of the directions provided by Dr. \_\_\_\_\_ and his/her staff.

You will have an opportunity to “test fit” your denture.

\_\_\_\_\_ I understand that I should not delay the test fit since a delay may result in a poorly fitting denture.

\_\_\_\_\_ I may request changes in the appearance of the denture during the test fit.

\_\_\_\_\_ I understand that after the test fit, the laboratory will finalize the denture.

\_\_\_\_\_ **I understand that after the denture has been finalized, any changes in its appearance that I request may result in additional charges to me.**

My dentist has asked me to give my final approval for the denture before it is sent to the laboratory for final adjustments.

I authorize and direct Dr. \_\_\_\_\_ to finalize the denture and approve the following:

\_\_\_\_\_ Color      \_\_\_\_\_ Size      \_\_\_\_\_ Shape      \_\_\_\_\_ Length  
\_\_\_\_\_ Width      \_\_\_\_\_ Arrangement

The denture is constructed to rest on top of your gum tissue. Since your gum tissue receives all of your chewing force, you may notice the following:

- *Pain or soreness*
- *Gag reflex may be activated*
- *Swelling*
- *Affected speech, such as slurring of some words*
- *Difficulty eating*
- *Redness*

\_\_\_\_\_ I understand that my dentist may need to make adjustments in my dentures or treat my gum tissue to relieve soreness. I may have difficulty adjusting to the denture because it feels very large and “foreign” in my mouth.

\_\_\_\_\_ I understand that it may take some time to adjust to my new denture.

\_\_\_\_\_ If I have difficulty with my denture, I understand that I should contact my dentist to schedule an appointment to adjust it.

\_\_\_\_\_ I understand that if I stop wearing my denture for an extended length of time, I may find that it no longer fits well. Without the denture base in place, the gum tissue may change shape or shift. Shifting of the gum may also occur over time. If this situation occurs, my dentist may need to readjust the base to my gums or even construct a new base.

\_\_\_\_\_ I understand that I should never try to adjust my denture myself with sharp objects or other devices. This action may cause damage to the denture that my dentist may not be able to repair.

\_\_\_\_\_ **Any adjustment made after 90 days may result in additional fees that will be charged to me.**

## Partial Dentures

A partial denture will be held in place by a device such as a clasp, rest, keyway, or lingual bar. Because your partial denture relies on a connection or attachment to your remaining teeth, these teeth may weaken over time. Denture material does not decay; however, your partial denture may trap food particles. Without thorough and regular brushing and cleansing of your partial denture, the teeth adjacent to it may become decayed, causing bad breath and periodontal disease.

\_\_\_\_\_ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

\_\_\_\_\_ Alternative methods and treatments, and their benefits, material risks, and disadvantages have been explained to me in terms I understand.

\_\_\_\_\_ I am aware and accept that no guarantees about the results have been made.

\_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative treatments.

\_\_\_\_\_ I have been informed of what to expect, including, but not limited to, estimated recovery time, anticipated activity level, and the possibility of necessary, unplanned, additional procedures.

\_\_\_\_\_ Pre- and post-treatment photos may be taken for record purposes. I understand that these photos will be the property of the treating dentist.

\_\_\_\_\_ I am satisfied that my dentist has answered all of my questions regarding this procedure and that I understand all of the terms of this agreement.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I further authorize the dentist(s) and any assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

\_\_\_\_\_  
*Patient or Legal Representative Signature/Date/Time*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Print Patient or Legal Representative Name*

\_\_\_\_\_  
*Witness Signature/Date/Time*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
*Dentist Signature/Date/Time*

\_\_\_\_\_ Copy given to patient  
*Initial*

\_\_\_\_\_ Original placed in patient's chart  
*Initial*