

Discussion and Informed Consent for Custom-Fitted Mouth Guard

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment: _____

Does the patient have any specific known allergies to: *(check only those that apply)*

___ Latex? ___ Vinyl? ___ Plastics? ___ Alginate?

Has the patient ever had an adverse reaction to a dental impression material? Yes No

(if yes, please explain) _____

I, _____ (please print your name clearly) am the parent/legal guardian of the above mentioned child and have the authority to give consent to treatment on behalf of said child.

Treatment Limitations

___ I understand that in this instance the treatment provided by Dr. _____ is solely related to the construction of a mouth guard and does not constitute a comprehensive dental examination or dental screening. Dr. _____ will not be taking X-rays, cleaning the teeth or diagnosing any dental condition.

Potential Risks or Complications

___ I understand that a custom-fitted mouth guard can play a significant part to preventing injury to teeth during athletic competition and practice, but it does not guarantee that injury to the teeth, gum tissue, head and neck will not occur.

___ I understand that loose teeth, fillings, crowns, veneers, orthodontic appliances or prostheses could become dislodged by the taking of the impression which may require repair or treatment recommendation by my child's regular dentist or a dental specialist.

___ I have been given an opportunity to ask questions regarding the procedure and all my questions have been answered to my satisfaction.

Patient/Parent or Legal Guardian's Signature

Date

Dentist's Signature

Date

Witness' Signature

Date