

INFORMED CONSENT FOR DENTURES  
IMMEDIATE AND CONVENTIONAL DENTURE ACKNOWLEDGEMENT FORM

Patient Name: \_\_\_\_\_  
Last First MI Preferred Name

Date: \* \_\_\_\_\_

IMMEDIATE AND CONVENTIONAL DENTURES

Denture Expectations: Facts for Consideration

1. They will not function like real teeth or implants.
2. They will move in the mouth even with the best retention possible.
3. They will cause occasional sore spots.
4. They may come loose while talking, eating and chewing or for no reason especially the lower complete denture.
5. Retention of dentures is based on the amount of bone and surface area present. Generally, upper complete dentures are more stable with better suction due to more surface area available.
6. Bone under these dentures change continually, especially under weight gain/losses. This may require occasional hard or soft relines of dentures.
7. Recommend yearly oral exam to check status of bone, tissue and dentures.
8. The more bone lost due to Periodontal Disease or badly broken down teeth, the less likely the dentures will have good retention.
9. Bony deposits or protuberances called tori make complete dentures contraindicated and may require a surgery to remove prior to denture fabrication.
10. Strong gag reflexes make complete dentures contra-indicated. The presence of a gag reflex may not be identified until the dentures are fabricated.
11. Bony ridges require approximately 8-10 weeks of healing before denture fabrication can be started.

Alternative Treatments:

1. Place implants in upper/lower bone to help retain dentures.
2. See Prosthodontist (specialist dealing with challenging denture cases)

I, being of lawful age, herby have been fully informed and completely understand all aspects associated with complete removal dentures. The advantages and disadvantages have been discussed along with alternative treatments if the desired outcome is not achieved.

The need for the service(s) and/or consultations(s) has been fully explained to me, along with the consequences of not having the services(s) performed.

I have discussed the matter with the doctor, all my questions have been answered, and I fully understand why the recommendations have been made.

☐ \* By checking this box, I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent or guardian (responsible party):

Signature \_\_\_\_\_ Date \_\_\_\_\_

I attest that I have discussed the risks, benefits, consequences and alternatives to teeth whitening with the patient/parents who had the opportunity to ask questions & I believe my patient/parents understands what has been explained.

Signature of Dentist/Provider:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Response Date: \_\_\_\_\_