Immediate Dentures

Consent

I understand that I have chosen to do an **immediate denture**. I have also been given the option to do a conventional denture. I understand that with an immediate denture that I am unable to try my teeth in before they are delivered to me, which these risks may apply:

- I cannot see the color of the teeth that I have chosen in my mouth.
- I am not guaranteed the sized or shape of my teeth.
- I am not guaranteed that my bite, overbite, underbite, or overjet will be corrected.
- I understand that additional surgery may be needed. Bone spicules (bone splinter) or excessive bone is sometimes common after multiple extractions. In this situation, additional surgery such as an alveoplasty or removal of bony spicules may be needed. There be an additional expense for these procedures.
- I understand my denture(s) will be delivered the same day my teeth are being removed.
- I understand that for an IDEAL fitting denture, all teeth should be removed first, then heal for one month, and impressions done after for a better fit. By choosing to do an immediate denture, I understand that I am skipping a try-in appointment. By doing so, I am not seeing the color, size of my teeth, and not evaluating the bite, overbite, or overjet.
- I understand that the overall esthetics, fit and function of the denture may be compromised.
- If the denture(s) does not fit, I will possibly need a reline, rebase, or a new denture. The above procedures are at an additional cost. It is possible that I may need to use denture adhesive to hold in my prosthesis.

________________________________    _______________ _______________
Patient Name (print)      Date

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Patient Signature
Immediate Dentures

Consent

I am content with the esthetics, size and shape of my denture(s). I am aware that there may be gum shrinkage involved with teeth being extracted on the same day. This may cause change in the fitment of the dentures and the dentures may need to be relined, rebased or redone completely at an additional charge.

________________________________    _______________ _________________
Patient Name (print)      Date

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Patient Signature