

**DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS'**  
**Informed Consent for Immediate Dentures**

I understand that immediate dentures means I will receive my dentures at the same time my teeth are removed. If my immediate dentures do not work, I understand that the Colorado Dental Health Care Program for Low-Income Seniors cannot be billed for another set of dentures for at least five (5) years. I also understand that the process of making and fitting dentures includes risks and possible failures.

By signing this form, I agree to accept those risks and the possibility that immediate dentures may fail. I also understand the following:

- Immediate Dentures will require more follow-up appointments for adjustments due to changes to bone and gums following tooth removal. My immediate dentures may need to be relined or replaced.
- I may have gum soreness from the immediate dentures and it may take several appointments before the immediate dentures fit comfortably.
- Poor-fitting dentures can cause constant irritation over a long period of time and sores may develop.
- Failure to wear my immediate dentures over a long period of time may affect how they fit.

***Informed Consent:*** I have had the chance to ask my dentist questions about immediate dentures and have received answers to my satisfaction. My dentist has told me about my treatment options and I do voluntarily assume any and all possible risks. No guarantees or promises have been made to me about my ability to use immediate dentures successfully or about how long my immediate dentures will last.

**My cost for this service has been explained to me. I fully understand that if I am not satisfied with the immediate dentures made for me, I cannot receive a refund. I also understand that if I wish to have my dentures replaced, I will be responsible for the full cost of replacement dentures.**

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date

**NOTE: This signed Informed Consent is to be kept with patient's file and be readily available if requested by the Department of Health Care Policy and Financing.**