

Informed Consent For Restorative Dentistry

I, _____, hereby give my consent for Brighton Specialty Dental Group to perform composite fillings on tooth/teeth #_____.

Diagnosis

I understand that this treatment is necessary due to one or more of the following conditions, which have been explained to me:

1. Dental caries (cavities)
2. Open (leaking) margins (edge of restorations) on existing restoration
3. Broken, fractured, or cracked tooth
4. Exploratory removal of existing restoration
5. Broken or fractured existing restoration
6. Amalgam or gold overhang
7. Improperly contoured existing restoration
8. Improper occlusal relationship on existing restoration
9. Improper tooth preparation of existing restoration
10. Poor esthetics of existing restoration
11. Missing tooth (teeth)
12. Root Canal treated tooth: significantly weakened

Alternative Treatment

I understand that alternative treatment is available and includes, but is not limited to, no treatment, temporary treatment, or removal of tooth. With no treatment, I can expect my condition to worsen after 2-4 weeks. With removal of my teeth, I can expect other problems such as tooth drifting, supra-eruption, and traumatic bite to develop.

Consequences of not performing treatment

If you do not have restorative treatment, existing problems caused by the shape or position of your teeth could result in further discomfort and possible damage to your jaw joints. For teeth that have received root canal treatment, failure to place a crown could lead to pain, infection and possibly the premature loss of the tooth. Decayed, Cracked or broken teeth or teeth with previous inadequate restorations could continue to deteriorate, causing pain, further decay, infection, deterioration of the bone surrounding the tooth and eventually, the premature loss of teeth.

Common Risks

- 1. Reaction to anesthesia:** To keep you comfortable while your tooth is being prepared, you will receive a local anesthetic. In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing, which increases the chance of swallowing foreign objects during treatment.

Other Risks of Local Anesthesia include but are not limited to:

- A. Prolonged or permanent anesthesia (numbness) or partial anesthesia (paresthesia).
 - B. Bleeding under the surface of the mucosa (tissue covering the inside of the mouth) which may cause swelling and discoloration of the inside of the mouth and/ or face, (Hematoma).
 - C. Rapid heart beat or other changes in Cardiac Rhythm and/or very rarely death.
- 2. Irritation to nerve tissue:** Preparing a tooth may irritate the nerve tissue (called the pulp) in the center of the tooth, leaving your tooth feeling sensitive to heat, cold or pressure. Treating such irritation may involve using special toothpastes or mouth rinses or Possibly treating the pulp itself (called endodontic or root canal treatment).

3. **Stiff or sore jaw joint:** Holding your mouth open during treatment may temporarily leave your jaw feeling stiff and sore and may make it difficult for you to open your mouth wide for several days afterwards. Treatment may leave the corners of your mouth red or cracked for several days.

4. **Changes to your bite:** A restoration may alter the way your bite fits together and make Your jaw joint feel sore. This may require adjusting your bite by altering the biting surface of the crown or adjacent teeth.

5. **Removable prosthesis** I further understand that if this restoration is one that is to be made to fit under an existing removable partial denture, retainer or Invisalign that there is a strong possibility that the removable prosthesis may not fit, and that it may then be necessary to remake my prosthesis or abandon its use, and that such additional treatment is not included in the cost of this restoration.

No Guarantees

I understand that in living things nothing can be predicted with certainty and that no guarantees, warranties, or promises, either implied or explicit, have been given as the outcome of this treatment. I further understand, however, that in Doctor's opinion, benefits outweigh the risk, and with successful treatment I can expect a healthy functional tooth.

I understand the above, and hereby give my consent to treatment.

Signed _____ Dated _____