Dentist 4 | Better bites, better smiles, better life.
better quality of life

D4-CONSENT FORMS-
FILLINGS

PROCEDURE INFORMATION

PATIENT NAME:

LAST	FIRST	MI	DATE OF BIRTH

PROCEDURE: **COMPOSITE FILLING**

PROCEDURE	TEETH (S)

DOCTOR NAME:

COMPLETE NAME

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

DETAILS OF CONSENT

Condition

My doctor has explained the nature of my condition to me: Tooth Decay (Cavities are permanently damaged areas in the hard surface of your teeth that develop into tiny openings or holes. Cavities, also called tooth decay or caries, are caused by a combination of factors, including bacteria in your mouth, frequent snacking, sipping sugary drinks and not cleaning your teeth well.

If cavities aren't treated, they get larger and affect deeper layers of your teeth. They can lead to a severe toothache, infection and tooth loss. Regular dental visits and good brushing and flossing habits are your best protection against cavities and tooth decay).

Procedure – Dental Filling

My doctor has proposed the following procedure to treat or diagnose my condition: Tooth Filling, are used to repair teeth that have suffered a cavity (a hole caused by the dental infection, tooth decay). The decayed tooth structure is removed, and the cavity is filled with a biocompatible material. Tooth-colored fillings, are made from a composite acrylic resin that resembles the color and appearance of your natural tooth structure. Using the discreet but effective resin.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of dental procedures and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental professionals.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that my Dental Caries may be restored with Tooth-colored fillings. I hereby authorize and direct the doctor and his assistants to treat my condition.
2. The procedure I choose to treat this condition is understood by me to be The decayed tooth structure is removed, and the cavity is filled with a biocompatible material. Using the discreet but effective resin.
3. Additional treatment procedures may include a direct or indirect placement of pulp protector, do a little adjustments on the opposite or adjacent teeth, root canal treatment, and others treatments. I understand that the purpose of this procedure is to allow me to have healthy teeth without any bacteria in my teeth.
4. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, a crown, an inlay/onlay ceramic restoration, or other options. I understand and choose to undergo the cavity filled with a biocompatible material (Tooth-colored filling).
5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure contained herein. I therefore authorize and request that the doctor and his assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.

6. I have had the opportunity to discuss with the doctor the planned procedure and my postoperative responsibilities. I should take any pain medication if i needed. If I experience an unusual amount of pain I should contact the doctor or his office immediately, as it may signify a problem.
7. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of aesthetic and restorative dentistry, there exists a risk of failure or necessity of additional treatment despite appropriate care. I have been advised that the restoration with a composite tooth colored filling has shown long term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the dentist. However, should I elect to have another doctor to do a new restoration, I am solely responsible for all costs and fees incurred in doing so and hereby release the doctor from any such costs and fees imposed by the other doctor.

Alternatives

My doctor has explained the following medically acceptable alternatives to be: A single crown, an inlay/onlay ceramic restoration, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me. If I don't have the procedure, the following may also happen: pain and/or infection, swelling, changes to my bite, pulp infection, and possibly the premature loss of other teeth.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are:

SENSITIVITY of TEETH: Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. This sensitivity may be mild to severe. This sensitivity may last for only a short period of time or may last for a much longer period of time. If such sensitivity persists or lasts for an extended period of time, I agree to notify the dentist as this may be a sign of more serious problems. This may result in the need for additional treatment including but not limited to an indirect pulp cat, root canal therapy or extraction.

RISK OF FRACTURE: Inherent in the placement or replacement of any restoration is the possibility of small fracture lines in the tooth structure. Sometimes these fractures may not be apparent at the time of removal of the tooth structure and/or the previous filling and placement or replacement but may manifest at a later time. This may result in the need for additional treatment including but not limited to root canal therapy and/or crown or possible extraction.

NECESSITY OF ROOT CANAL THERAPY: When fillings are placed or replaced the preparations of the teeth for fillings often necessitates the removal of tooth structure adequate to insure the complete removal of the diseased or otherwise compromised tooth structure. This exposes sound tooth structure for the placement of the restoration. At times, this may lead to exposure or trauma to the underlying pulp tissue. Should the pulp not heal, which often time is exhibited by extreme sensitivity or possible abscess, root canal therapy or extraction may be requires. If root canal therapy is required, a crown will be necessary in most cases.

BREAKAGE, DISLODGEMENT, AND/OR FAILURE: Due to extreme biting pressures or traumatic forces, it is possible for composite fillings or aesthetic restorations to be dislodged or fractured. The resin-enamel bond may fail resulting in leakage and recurrent decay. The dentist has no control over these factors.

NEW TECHNOLOGY & HEALTH ISSUES: Composite resin technology continues to advance but some material yields disappointing results over time and some fillings may have to be replaced by better, improved materials. Some patients believe that having metal fillings replaced with composite fillings will improve their general health. This notion has not been proven scientifically and there are no promises or guarantees that the removal of silver fillings and the subsequent placement of composite fillings will improve, alleviate, or prevent any current or future health conditions.

I understand it is my responsibility to notify this office should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed.

There will be no refund of fees from the dentist in the event of complications requiring additional procedures to salvage the teeth.

Drugs, Medications, and Anesthesia

Pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection.

No guarantee

The practice of dentistry is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

MY RESPONSIBILITY

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health. It is my responsibility to see the doctor at least once a year for evaluation and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after procedure to ensure success in the restoration.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

MISCELLANEOUS

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this procedure, and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

SIGNATURE

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. _____ to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

Patient or Representative Signature **Date**

If not the patient, what is your relationship to the patient?

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

Dentist Signature **Date**