

Avery Ranch Dental

Consent for Crown and Bridge Treatment

Patient's Name

Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ 1. CROWNS AND BRIDGES

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary restorations that are prone to loosening and falling off and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of restoration must be made prior to final fabrication. It is my responsibility to schedule and return for final cementation of the restorations. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility. I also understand that if my tooth does not respond to treatment with a crown or bridge, further treatment such as root canal therapy may be necessary.

_____ 2. DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions which, although rare, can lead to death. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. RISKS OF DENTAL ANESTHESIA:

I understand that pain, bruising and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with local anesthetics. About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____ 4. Due to the unique difference in each patient's oral cavity and oral hygiene abilities there is a risk for relapse, recurrence, and failure of restorations. It is the doctor's opinion that therapy will be helpful and worsening of the conditions would occur sooner without the recommended treatment

_____ 5. CHANGES IN TREATMENT PLAN:

I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care and understand that the fee proposed is subject to change, depending upon those unforeseen or undiagnosed conditions that may only become apparent once treatment has begun.

CONSENT: My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's or Guardian's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date