Avery Ranch Dental

Consent for Fillings

_____ _____

Patient's Name *Date*

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

_____ 1. FILLINGS:
I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during tooth preparation. I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that if my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns. 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.

_____ 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 always a risk for relapse, recurrence, and/or failure of restorations. I understand that it is impossible to predict if and how fast my condition would worsen if untreated, but it is the doctor's opinion that therapy would be helpful and worsening of the condition(s) 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