

**ALL SMILES DENTISTRY
CONSENT FOR CROWN/ BRIDGE TREATMENT**

We believe that you have right to be informed about your condition, treatment options, and risks vs. benefits so that you may make a knowledgeable decision as to whether or not to undergo the crown or bridge. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may make your decision.

PATIENT NAME: _____ DATE _____

_____ Please **initial each paragraph** after reading and agreeing. If you have any questions please ask the staff any questions before initialing.

_____ I hereby authorize **Dr. Steinhubel** and any other employees selected by him, to treat the condition(s) described as....

Prior restoration on following surfaces: _____

New decay present on following surfaces: _____

Fractured or missing following tooth structure: _____

Symptoms: _____

_____ The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s) to be that **tooth#(s)** _____ will be reduced of the outer enamel layer and some of the second dentin layer to allow room for a crown("cap") to fit over the tooth and within the bite. The removal of tooth structure is irreversible, however necessary for the procedure and the treatment goals. Additionally, a foundation filling called a "build-up" if often needed to replace an existing filling or missing tooth structure that the crown needs to rest on.

_____ There are **different materials** that crowns can be made from. Dr. Steinhubel suggests a LAVA (non-metal crown). You can also choose to have a Gold crown or Gold substructure/ white porcelain outside crown. Please let our staff know before proceeding with your appointment if you would like something other than a LAVA crown.

_____ I have been informed of the pros and cons of possible **alternative methods of treatment** including
-NO TREATMENT, understanding the condition will normally worsen
-Large filling (considered unstable and unfavorable prognosis, therefore not recommended)

There are also certain potential risks and side effects to such dental procedures and in this specific instance such risks include, but are not limited to, the following:

_____ Removal of tooth structure can sometimes lead to **temperature sensitivity** or irreversible tooth pulp inflammation that may necessitate a **root canal** in the near or distant future, and hence a new crown.

_____ **Biting sensitivity** that may require possible multiple appointments to adjust the temporary and/or the permanent crown.

_____ Inadvertent injury or damage to **adjacent teeth, restorations, or soft tissue**.

_____ Restricted mouth opening that can last for days; sometimes related to swelling and muscle soreness and sometimes related to stress on the joints of the jaw (**TMJ**).

_____ I consent to the administration of **local anesthesia** in connection with the procedure(s) referred to above. I understand local anesthetic is used in most dental procedures and carries the risk of: **Numbness**, tingling, diminished function of the lip, gums, chin and/or tongue which may last from several days to several months; or partial or total numbness which may be permanent.

If I have an **existing crown** it could hold some value.

_____ I elect to have my crown given to me

_____ I elect to NOT have my crown returned to me

_____ A **temporary crown** is used during the week(s) between preparation and cementation appointments. The temporary crown:

Modifies my **diet and hygiene** while it is in place.

Requires that I am cautious not to **ingest or aspirate** it.

Can come off or break requiring a **recementation or refabrication** appointment(s).

_____ I **must come in for a second appointment to cement final crown in approximately two weeks. If I do not return in a timely manner the tooth can move, become diseased, etc.. Making it necessary to remake crown, necessitate additional procedures, or tooth loss and additional cost is my responsibility.**

_____ It has been explained to me that during the course of the procedure(s) **unforeseen conditions may be revealed** which will necessitate extension of the original procedure(s) or different procedure(s) from those set forth above. I authorize my doctor and his staff to perform such procedure(s) as are necessary and desirable in the exercise of professional judgment.

CONSENT: I have read and understand the above paragraphs and realize that a perfect result cannot be guaranteed. All my questions have been fully answered to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read, and write English or have had an interpreter explain this consent form to me.

Patient's (or legal guardian's) signature

Date and Time

Printed name

Witness'/ Assistant Signature

Date

Doctor's signature

Date

Thank You!