

RESTORATIVE DENTISTRY

Restoration is a term used in dentistry to describe restoring the function of the tooth by replacing missing or damaged tooth structure. Restorations are classified as either:

- **Direct**, where the restoration is fabricated, or made, inside the mouth. An example would be a composite filling.
- **Indirect**, where the restoration is made outside of the mouth. An example would be a crown.

*Patient's
Initials*

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of _____ are not limited to:

(Procedure Name)

___ *Pain*

___ *Bruising*

___ *Swelling*

___ *Infection*

___ *Alteration in taste*

___ *Numbness of the lip, tongue, chin,
cheek(s), or teeth*

___ *Sinus penetration*

___ *Bone fractures*

___ *Delayed healing*

___ *Affected speech*

___ *Potential soft tissue surgery*

___ *Visible implant injury to teeth*

___ *Failure of implant, resulting in need
for removal or possible bone loss*

___ *Dislodgement of adjacent fillings*

_____ I understand that by signing this consent, I am in no way obligated to proceed with any treatment.

_____ I understand that it is not always possible to match the color of artificial teeth exactly to natural teeth.

_____ I further understand that I may need to wear a temporary crown, which has limited durability, so I must treat it gently until the permanent crown is cemented in place.

_____ I understand that the final opportunity to request changes (shape of, fit, size, and color) will be before cementation.

_____ It is also my responsibility to return for permanent cementation within 30 days of the tooth impression. Excessive delays may allow for tooth movement, which may necessitate remaking the crown or bridge.

_____ I understand that there will be additional charges if I have delayed permanent cementation.

_____ I understand that porcelain/ceramic materials may fracture and that I will be financially responsible for any replacements.

_____ I understand that I must be careful when chewing on newly filled teeth, especially during the first 24 hours.

_____ I understand that a more extensive restorative procedure than originally diagnosed may be required if additional or widespread decay is found.

SAMPLE

- _____ I understand that significant sensitivity is a common aftereffect of a newly placed filling.
- _____ I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, such as redness, swelling tissue, pain, itching, vomiting, and/or anaphylactic shock.
- _____ I understand that I must provide a complete medical and personal history, follow all instructions as directed, and permit prescribed diagnostic procedures.
- _____ I have informed the dentist of all my known allergies.
- _____ I also acknowledge that during treatment it may be necessary to change or add procedures due to conditions not discovered during examination. For example, root canal therapy following routine restorative procedures might be necessary.
- _____ I acknowledge that no guarantee or assurance has been made by anyone regarding the success of the dental treatment that I have requested and authorized.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, DDS/DMD/MD,
(Dentist Name)
 with associates or assistants of his or her choice, to perform the procedure of _____ on
(Procedure Name)
 _____ at
(Patient Name)
 _____.
(Facility Name)

I further authorize the dentist(s)/oral surgeon(s) and any assistants to perform any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

<i>Patient or Legal Representative Signature/Date/Time</i>	<i>Relationship to Patient</i>
<i>Print Patient or Legal Representative Name</i>	<i>Witness Signature/Date/Time</i>

I certify that I have explained to the patient or the patient's legal representative the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/ treatment and the risks and consequences of not proceeding. I have answered all questions fully, and I believe the patient/legal representative (circle one) fully understands what I have explained.

_____ *Dentist/ Surgeon Signature/Date/Time*

_____ Copy given to patient
Initials

_____ Original placed in patient's chart
Initials