

Discussion and Informed Consent for Filling(s)

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment & Tooth Number(s): _____

I understand that by signing below I am authorizing the procedure(s) to be performed and I have read and understand the entirety of this form, including the possible risks and complications of the chosen procedure(s) and the available alternatives.

Important Information:

Patient's initials required

Fillings

_____ Fillings are used to protect a sensitive surface of the tooth, to replace tooth structure, relieve pain, cover an eroded area and fill in a hole or space in the tooth structure.

_____ I understand that care must be exercised in chewing after the placement of fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay present at the time of treatment. Following a filling, there may be sensitivity of the teeth that can last for a short period of time. If the sensitivity continues, I will notify my dentist as this can be a sign of more serious problems. During the preparation for a filling, the removal of tooth structure may lead to exposure or trauma to underlying nerve or pulp tissue. Extreme sensitivity or possible abscess often indicate that the pulp did not heal. If that is the case, a root canal treatment or extraction may be required. Because of extreme masticatory (chewing) pressures or other traumatic forces, it is possible for fillings to become dislodged or fracture. The resin-enamel bond that adheres the filling material to the tooth structure can also fail resulting in leakage and recurrent decay.

_____ I understand that delaying treatment may cause harm, the dental disease may progress, further damage to teeth may occur and swelling and infection may occur creating additional treatment and associated expenses.

Local Anesthesia

_____ In connection with my dental work, local anesthetic may be used for pain control during dental procedures. All anesthetics create risks and possible side effects. These include, but are not limited to, swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction and altered sensation that may lead to biting the lip or tongue. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and occasionally may be permanent.

Types of Available Fillings:

Please check the appropriate box:

☐ Composite (tooth-colored filling): Resin or white fillings have an advantage of allowing a more "conservative" tooth preparation, can have a strengthening effect on the tooth, have improved aesthetics and virtually blend in with the natural tooth. Risks involved with a composite filling include, but are not limited to, sensitivity of teeth, risk of fracture lines in the tooth structure, necessity for root canal therapy, injury to the nerves, shade variation of the filling, alteration in speech, breakage, dislodgement or bond failure because of pressures or other traumatic forces.

☐ Amalgam (silver and mercury containing): Mercury has been used for decades as a component of filling material for teeth. In recent years, however, some opponents to the material have asserted that there is a possibility, although unproven, that silver amalgam may have an effect on the general health of a person due to its mercury content. Occasionally shavings generated by placement or carving of silver amalgam fillings may work their way within the surrounding oral tissues and become lodged. Over an extended period, gray spots or "tattoos" may become visible within the mouth.

_____ **I have reviewed the Dental Materials Fact Sheet.**

Check the boxes below that apply to you:

Consent

- ☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.
- ☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.
- ☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. _____ to do whatever he/she deems necessary and advisable under the circumstances.
- ☐ I consent to have the above-mentioned treatment.
- ☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

- ☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

Patient or Patient's Representative

Date

Witness Signature

Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

Dentist Signature

Date

Tooth # _____ Date: _____ Patient Signature: _____

Tooth # _____ Date: _____ Patient Signature: _____

Tooth # _____ Date: _____ Patient Signature: _____

Tooth # _____ Date: _____ Patient Signature: _____

Tooth # _____ Date: _____ Patient Signature: _____

Tooth # _____ Date: _____ Patient Signature: _____