Consent for Fillings

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

_____ 1. **FILLINGS:**
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**. 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 understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during tooth preparation. 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. Any additional fees will be discussed prior to significant changes.

I understand it is my responsibility to maintain proper oral hygiene at home and maintain my routine dental cleanings and exams to help keep dental restorations from needing additional treatment. Not doing so could result in additional treatment or having the same treatment redone at full cost out of pocket.

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 Dr. Mitchell and I have chosen.

_____

Patient or Guardian Signature Relationship to patient Date

Printed Name: _____ Tooth #: _____