DISCUSSION AND CONSENT FOR CROWN RESTORATIONS

Patient's Name: _____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning, I wish to be provided with sufficient information, in a way I can understand, to make a well informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish**, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

NATURE OF CROWN RESTORATIONS

A crown restoration has been recommended for me on the following tooth (teeth):_____

Crown restorations cover and protect teeth that have been weakened by decay, prior restorations, or root canal treatment. Crowns can also be placed to change the bite or for cosmetic purposes. Crowns usually require at least two visits to complete treatment. At the first visit, the dentist will reduce the size of the tooth. This makes room for the crown itself to fit on the remaining portion of the tooth, called the preparation. After the reduction is completed, an impression, or mold, of the preparation is made using a rubbery material. A plastic temporary crown is held on the tooth with temporary cement while the crown restoration is being made by a dental laboratory. It is important to return for the cementation of the new crown as soon as it is ready in order to reduce the chance of the new tooth decay or other problems.

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wishes have also been considered. The crown restoration is necessary because of:
_____Extensive decay _____Broken Tooth _____Decay around large prior filling _____Changing my bite _____Cosmetic purposes
Other:_____

The intended **benefit** of a crown restoration is to replace missing natural tooth structure and restore the tooth to normal function and/or improve the shape and color (cosmetics) of the tooth (teeth). The crown restoration also may relieve current symptoms of discomfort I may be having.

The prognosis, or likelihood of success, of this treatment is_____.

My crown restoration(s) is/are estimated to cost$_____ and is estimated to take _____ visit(s) to complete.

ALTERNATIVES TO CROWN RESTORATIONS

Depending on my diagnosis, there may or may not be alternatives to a crown restoration that involve other types of dental care. I understand that possible alternatives to crown restorations may be:

- Other restorative alternatives, such as onlay, inlay, veneer or a filling. Fillings may be made of dental amalgam(silver) or a tooth-colored filling material
- Extraction. I may decide to have tooth #_____ removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant with a crown, or a removable partial denture.
- No treatment. I may decide to have no treatment performed at all. If I decide upon no treatment, my condition may worsen and I may risk serious personal injury, including severe pain; localized infection; loss of this tooth and possibly other teeth; severe swelling; and /or a severe (spreading) infection.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including_____.
Patient's Initial

RISK OF CROWN RESTORATIONS

I have been informed and fully understand that there are certain inherent and potential risks associated with crown restorations. I understand that the nerve inside my tooth may be irritated by treatment and I may experience pain or discomfort during and/or after treatment. My tooth may become more sensitive to hot and cold liquids and foods. I understand that root canal treatment may become necessary at any time during or after treatment and may not be avoidable. I understand that a crown restoration may not relieve my symptoms.

I understand that once prior fillings and decay are removed, it may reveal a more severe condition of my tooth. This condition may require periodontal (gum) surgery to uncover more of the tooth, may require root canal treatment in addition to a crown restoration, or may instead require the extraction of the tooth.

I understand that I may notice slight changes in my bite. I understand that during and for several days following treatment, I may experience stiff and sore jaws from keeping my mouth open.

I understand there may be injury to my gums around the tooth. I understand that my gums may recede after the completion of my crown restoration. I understand that poor eating habits, oral habits (smoking, fingernail biting, etc), and poor oral hygiene will negatively affect how long my crown lasts.

I understand that I will be given a local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that The injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection.

I understand that once a crown restoration is started, I must promptly return to have the crown finished. If I fail to return to have the crown completed, I risk decay, the need for root canal treatment, tooth fracture and loss of the tooth.

Other foreseeable risks not stated above include:_____

_____ I have had an opportunity to ask questions about the risks and any other risks I have heard or thought about, including _____

Patient's Initial

ACKNOWLEDGEMENT

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended crown restoration is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.
I wish to proceed with the recommended treatment.

_____ I understand this treatment can also be performed by a prosthodontist (a crown specialist). I understand the risks and elect to have this procedure performed by Dr. _____. I understand that if any unexpected difficulties occur during treatment, I may be referred to a prosthodontist for further restorative care of this tooth.

Patient's Initial

Signed: _____ Date:_____
Patient or Guardian

Signed: _____ Date:_____
Treating Dentist

Signed: _____ Date:_____
Witness