LIBBY DENTAL

Inspiring Health & Happiness

CONSENT FOR CROWN RESTORATION

Patient's Name _____ Date of Birth_____
Last First Initial

I am being provided this information and consent form so I may better understand the treatment recommended for me. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well-informed and confident 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 require at least two visits to complete treatment. At the first visit, the dentist uses the drill to reduce the size of the tooth. This makes room for the crown itself to fit on the remaining stump of tooth, called the *preparation*. After drilling is complete, 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 redecay 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 wants have also been taken into consideration. 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. The crown restoration may also relieve current symptoms of discomfort I may be having.

The prognosis, or chance of success, of this treatment is _____.

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 amalgam (silver) or tooth colored filling
- Extraction. I may choose to have tooth # _____ removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- No treatment. I may choose to not have any treatment performed at all. If I choose 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 severe infection.

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 point 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 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 adjacent to 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 instances 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 holding my mouth open during treatment.

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 finished, I risk decay, the need for root canal treatment, tooth fracture and loss of the tooth.

Other foreseeable risks not stated above include: _____

Acknowledgment

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 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. Landon Libby 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, and the risks of the recommended treatment.

I wish to proceed with the recommended treatment.

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

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist