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INFORMED CONSENT FOR RESTORATIVE TREATMENT (FILLINGS, CROWNS, ETC.)

My child has been diagnosed as having either a fractured tooth or one or more caries (carious lesion, commonly referred to as "cavities") in his/her teeth. Dental caries is a disease in which bacterial processes damage hard tooth structure. The bacteria which causes tooth decay occurs in the presence of sugars. Prevention of dental caries improves with proper diet, fluoride therapy, use of dental sealants, and regular dental examinations and cleanings. Treatment of dental caries involves the removal of the decay and replacement of the missing tooth structure with a dental restoration. Restorative materials include various composite fillings (tooth-colored). When the decay is too extensive, the patient is high risk for cavities, a defect in the tooth structure exists, along with other reasons, there may not be enough tooth structure remaining to allow a filling/restorative material to be placed within the tooth. In such cases, a stainless steel crown (silver cap) may be recommended to cover the whole tooth.

I have been informed that restorative treatment **(Composite restoration, Stainless Steel Crown/Cap, Other)** of my child's dental caries is recommended. I have also been informed that such treatment includes possible risks, such as but not limited to the following:

Local anesthesia or "numbing" is often used to make the treatment more comfortable. The risk of local anesthesia include bruising or swelling at the injection site, possibility of long term numbness to the lips, cheek, gums or tongue that usually resolves itself and temporary (a few minutes) acceleration of the heart rate or blood pressure.

As with all procedures, there are potential things that may occur:

1. Possibly numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the numbing agent/anesthetic administration or from treatment procedures. This numbness is usually temporary, but rarely could be permanent.

2. Tooth/teeth may become sensitive to hot and cold liquids or foods. *Root canal treatment may become necessary due to the extent of decay at any point during or after treatment and may not be avoidable. If I noticed an abscess is noted on the gums ("bubble", or "blister"), I will notify my Dr. immediately. In the worst case situation, the tooth may need to be extracted.

3. Possibility of injury to gums adjacent to the teeth being treated. Local swelling may exist.

4. Possibility of gum recession after the completion of the restoration.

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5. Poor eating and oral habits (fingernail biting, etc.), poor oral hygiene, and tongue piercings will negatively affect how long my restorations last.

6. Certain medications have a side effect of xerostomia aka "dry mouth." Daily use of a prescription strength fluoride may be recommended to prevent cavities around the restoration(s) as well as my natural teeth.

7. My child's jaw may be temporarily stiff and/or sore from holding my mouth open during treatment.

8. My child's bite may need to be adjusted after the restoration(s).

9. Fracture of the filling or tooth may occur, requiring replacement, change of filling material or possibly a crown. If a severe fracture occurs or is found, the tooth may need to be extracted.

10. It is possible for new future decay to occur around or underneath a filling. Proper care and cleaning of my teeth can help to avoid this.

11. Sensitivity to heat, cold, air, biting may persist after restorations are completed. If any questions arise, please call us to discuss any symptoms your child may have.

12. My child may need a "baby root canal" or adult proper root canal underneath this crown due to depth of the decay. I have discussed what this means with my doctor/dentist.

Informed Consent: I have been given the opportunity to discuss and ask any questions regarding the nature and purpose of restorative treatment for dental caries, and have received answers to my satisfaction. I do voluntarily understand and accept any and all possible risks including, but not limited to, those listed above. The fee(s) for these services have been explained to me and are satisfactory to me. I understand that future treatment occurring as a result of the possible risks outlined above shall be charged additionally. By signing this document, I am giving my consent to allow and authorize PDO and its associates to render any treatment necessary and/or advisable to my child's dental condition(s), including prescribing and administering any and all anesthetics and/or medications.

_____ _____

Parent/Guardian's Signature Name of patient receiving treatment

_____ _____

Today's Date Witness's Signature