



Consent for Composite Fillings

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Patient First Name:	Patient Last Name:	DOB:	Tooth #(s):
_____	_____	_____	_____

The purpose of this document is to provide written information regarding the risks, benefits and alternatives of the procedures named above. This material serves as a supplement to the discussion you have with your dentist. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your dentist prior to signing the consent form.

THE PROCEDURE

A composite filling is a procedure where the doctor will be treating active decay, a cracked or broken restoration, or restoring a malformed tooth with a “tooth colored” resin composite. Composite restorations will be performed using a topical anesthetic and an injectable local anesthetic. Local anesthetics result in loss of sensation for oral tissues and teeth (typically for 45 minutes up to 3 hours) depending on the type of injection used. The doctor will use dental burs and hand instruments to remove decay, spray water to remove debris and use an etchant to prepare the tooth for the composite placement. A bonding agent will be activated with a curing light to adhere the composite resin to your tooth. The curing light will permanently harden the filling before your appointment is over. A colored piece of articulating paper is used to check your bite for “high spots” that may need to be adjusted. In some cases, it requires the anesthetic to be completely worn off before your new filling feels normal.

BENEFITS

Potential benefits of a composite restoration: * Replaces tooth structure lost due to caries (decay), trauma, or fracture. * Restores proper form and/or function and provides the ability to better keep tooth structure clean at home with proper oral hygiene.

RISKS

Known risks for a composite filling include but are not limited to the following: * Need for further treatments in the future, such as root canal therapy, crowns, or extractions. * Damage to adjacent teeth and/or tissues. * Damage to nerves in the area of local anesthetic administration which can be temporary or permanent. * Changes in occlusion (bite). * Mild, moderate, or severe sensitivity of teeth. * Injury to the nerves of the lips, jaw, teeth, tongue, or other facial tissues. * Fracture, leakage, and/or recurrent decay requiring re-treatment of fillings. * Sensitivity to cold, heat, or sweets. This is often temporary but may be permanent.

CONTRAINDICATIONS

Allergy to dental restorative materials or sealants Sulfite allergy (component of local anesthetic) Fluoride allergy (Some materials used throughout the filling process may contain fluoride) Abscessed (infected) tooth or teeth with spontaneous (unsolicited) pain

ALTERNATIVES

Additional risks may be associated with alternative treatment methods to treat active decay. These treatment options include (but are not limited to): * No treatment (may increase chance for caries (decay) progression and lead to more extensive treatment needs.) * A crown and core build up to provide full coverage to the tooth. * Extractions and/or space maintainers.

CONSENT

I understand that my diet and oral hygiene will influence the longevity of dental fillings. If decay forms around fillings, they may need replacement or more extensive treatment. Such treatment may or may not be covered by my dental insurance. I further understand that my dental insurance plan may downgrade coverage for composite restorations. This would result in a higher copay for composite fillings versus amalgam (silver) fillings (which are no longer offered at this office).

By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my consent for this procedure. The advantages, risks and alternative treatments have been explained to me by the doctor and the doctor has answered all my questions to my satisfaction. I understand that it is impossible to state every complication that may occur as a result of my teeth being treated with composite restorations, and that the above list of risks/complications in this form is incomplete. I fully understand this procedure and the possible risks, complications and benefits that can result from the composite restorations and that I agree to undergo the treatment as described by the doctor.

Signature of Patient, Parent, Guardian or Personal Representative:	Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient:
<div>Sign</div> <div>_____</div>	_____