Consent for Stainless Steel Crown - Pediatric

Patient First Name: Patient Last Name: DOB:

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 child's 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 the doctor prior to signing the consent form.

Tooth(s) #:

THE PROCEDURE

- ☐ A stainless steel crown restores the form and function of a tooth. If a deciduous (baby) tooth has too much dental decay to warrant a filling, then a stainless steel crown should be placed. A stainless steel crown is a very durable restoration. Stainless steel crowns are commonly used on deciduous (baby) teeth. If the tooth has had a pulpotomy (root canal), a stainless steel crown is often placed afterward. Only a stainless steel crown is likely to remain intact for the life of the tooth. Baby teeth which have had pulpotomies tend to become brittle and are more likely to break if a large filling only is placed. Failure rates for stainless steel crowns are less than 1% per year. Our goal is to achieve the best clinical outcome by using the least invasive treatment and avoid investing in a treatment that doesn't last.
- ☐ Your child will be given a local anesthetic before their procedure. With local anesthesia, an injection of drugs causes numbness in the exact location of this dental procedure to minimize pain. Your child may still feel pressure which can often be uncomfortable to some children, but should not cause pain. Nitrous oxide (see additional consent) is typically used to help with patient comfort during a crown procedure. Your child's doctor may use dental hand instruments or a dental bur to remove decay in the tooth, and use a resin or amalgam material to rebuild the compromised tooth structure. Water may be used throughout the procedure to flush debris. A stainless steel crown will then be fit and adhered to the tooth, covering the entire biting surface, and sides of the tooth.

RISKS

Known risks of this treatment include, but are not limited to: • Bleeding, bruising and/or swelling at the injection site • Discomfort from incomplete numbing of the area. • Incomplete relief of pain. • Breakage of adjacent teeth or trauma to the gums. • Sensitivity or pain in treated teeth. In some cases additional treatment may be required. • Allergic or adverse reaction to local anesthesia or other medicines given during or after the procedure. • Damage to the facial nerve(s). This may change the appearance of your child's face or make their tongue weak or numb. It may cause partial or complete paralysis of the face.

ALTERNATIVES

- ☐ As with any dental procedure you can choose not to proceed with care. Of course, that decision has its own set of benefits and risks. The tooth may break and require an extraction. If the tooth is extracted, the remaining teeth may shift and require future orthodontics to reposition the permanent teeth.

SEDATION

- ☐ • Nitrous Sedation: Nitrous oxide laughing gas inhalation is a mild form of conscious sedation used alongside local anesthetic to calm an anxious child during a dental procedure. (additional consent required)

CONSENT

- ☐ By signing below, I attest to the following: I have provided my childs accurate and complete medical and/or personal history. Including antibiotics, drugs, or other medications my child is currently taking, as well as those to which my child is allergic. I will follow any and all treatment and posttreatment instructions as explained and directed to me, on behalf of my child. I realize that in spite of the possible complications and risks, my child's stainless steel crown is necessary. I acknowledge that there can be no guarantees concerning the results of my child's procedure. I understand that if any unexpected difficulties occur during or after treatment that my child may be referred to a specialist for further care. Someone has explained this treatment/procedure and what it is for. Someone has explained how this procedure could help my child, and also reviewed the associated risks and complications. Someone has explained to me the alternative treatments that might be done instead, and what would happen if I decline for my child to undergo this procedure. Someone has answered all my questions. I have been offered the opportunity to read the consent form. I hereby give my consent to have this treatment/procedure performed on my child.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient: