Consent for: Composite (White) Fillings

1) The following informed consent form for restoration treatment for the condition(s) described as either: caries ("cavity"), recurrent caries ("cavity under my previous filling") or abrasion ("wear on the tooth structure close to my gum") or a fracture
2) The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be: **composite (white) filling**
3) The prognosis for this (these) procedure(s) was described as either: excellent, good, fair, questionable, or poor.
4) I have been informed of possible alternative methods of treatment including:
   - **A.** No treatment at all
   - **B.** Amalgam restoration
   - **C.** Inlay or onlay (gold or porcelain)
   - **D.** Extraction
   - **E.** _____
5) I consent to the administration of local anesthesia in connection with the procedure(s) referred above, if necessary. I understand that administration of local anesthesia involves risks including pain, paralysis, injury and rarely, even death.
6) Complications with local anesthesia although rare can include swelling, bruising, pain, infection, nerve damage, and unexpected allergic reaction, which could lead to a heart attack, stroke, brain damage and/or death.
7) **I UNDERSTAND** that the treatment of my dentition involving the placement of composite resin fillings which may be more esthetic in appearance than some of the conventional materials which have been traditionally used, such as amalgam (silver) or gold may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this treatment. These risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:
   - **A. Sensitivity of Teeth:** Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity may be mild to severe. The sensitivity may last only for a short period of time or may last for much longer periods of time. If such sensitivity is persistent or lasts for much extended periods of time, I agree to notify the dentist in as much as this may be a sign of more serious problems.
   - **B. Risk of Fracture:** Inherent in the placement of replacement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and the placement or replacement, but may manifest at a later time.
   - **C. Necessity for Root Canal Therapy or Extraction:** When fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure adequate to insure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to the exposure or trauma to the underlying pulp tissue. Should the pulp not heal, which often times is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

D. **Numbness:** there is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissue from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances could be permanent. If this numbness persists for a period of time longer than 24 hours, please call the office.

E. **Esthetics or Appearance:** Effort will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, smoking, etc., may cause the shade to change. The dentist has not control over these factors

F. **Breakage, dislodgement or bond failure:** Due to extreme masticatory pressure or other traumatic forces, it is possible for composite resin fillings or esthetic restorations bonded with composite resins to be dislodged or fractured. The resin-enamel bond may fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

G. **New Technology and Health Issues:** Composite resin technology continues to advance but some materials yield disappointing results over time and some fillings may have to be replaced by better, improved materials. Some patients believe that having metal fillings replaced by composite fillings will improve their general health. This notion has not been proven scientifically and there are no promises or guarantees that the removal of silver fillings and the subsequent replacement with composite fillings will improve, alleviate, or prevent any current or future health condition.

8) **I understand that it is my responsibility to notify this office should any undue or unexpected problems occur, or if I experience any problems relating to the treatment rendered or the services performed.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of composite (white) filings and have received answers to my satisfaction. I do voluntarily assume any and all possible risk including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises of guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. Lee and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition, including the administration and/or prescribing of any medications and/or anesthetics deemed necessary to my treatment.

Patient's Name (please print):_____

Patient's (or legal guardian's) Signature: _____

Date/Time _____

Doctor's Signature: _____ Date/Time _____

Witness's Signature: _____ Date/Time _____