

**Innovative Dentistry
Informed Consent for Crown Restorations
Angela M. Catalano, DMD**

Patient's Name _____ Date _____

I am being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning, I have been provided with enough information, in a way I can understand, to make a well informed 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 Restoration

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. We have a milling machine and can complete the crown in one visit, however, crowns usually require at least two visits to complete treatment. At the first visit, the dentist will reduce the size of the tooth. This allows room for the crown itself to fit on the remaining portion of the tooth, called the preparation. After reduction is completed, 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 becomes available to be seated to reduce the chance of recurrent decay or further 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 wishes have also been taken into consideration. The crown restoration is necessary because of:

Extensive Decay Broken Tooth Decay around a large prior filling Cosmetic purposes

Recurrent decay or open margin on an existing crown Other

The intended benefit of a crown restoration is to replace missing natural tooth structure and to retain the core of the tooth, which will restore the tooth to its natural function. The crown restoration also may relive current symptoms of discomfort I may be having.

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 possible alternatives to crown restorations may be:

Other Restorative alternatives, such as onlay, inlay, veneer, or tooth colored filling

Extraction- I may decide 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.

No treatment- I may decide not to have treatment performed at all. If I decide upon 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 had an opportunity to ask questions about these alternatives and any other treatments Patient Initials

Risks of Crown Restorations

I have been informed and fully understand that there are certain inherent and potential risks associated with crown restorations. I

understand 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 time during or after treatment and may not be avoidable. I understand that a crown restoration may not provide relief to my symptoms.

I understand once prior fillings and decay are removed, it may reveal a more severe condition of my tooth. This condition may require periodontal (gum) surgery to uncover more of the tooth, may require root canal treatment in addition to a crown restoration, or may instead require an extraction of the tooth.

I understand 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. If this occurs, I understand I should notify Dr. Catalano immediately; otherwise, the condition may get worse if not corrected accordingly. I understand crowns will not correct any TMD issues.

I understand there may be injury to my gums from the cord or laser used to reflect the tissue away from the crown preparation. I understand my gum may recede after the completion of my crown preparation. I understand poor eating habits, oral habits (smoking, fingernail biting, etc.), and poor oral hygiene will negatively affect how long my crown lasts.

I understand I will be given a local anesthetic injection that in rare situations, patients have had allergic reactions to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels for 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 completed. 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.

Risk Factors: Epinephrine (EPI) can cause increased heart rate, normal when receiving an injection. It should subside in 15 minutes. Anterior region injections can hit the nerve artery and cause a minor bloody nose.

Acknowledgement

I have provided as accurate and complete medical and personal history as possible, including antibiotics, drugs and 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, warranties, or representations have been made to me concerning the results of treatment.

I, _____ have received information about the proposed treatment. I have discussed my treatment with Dr. Catalano 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, the risks of the recommended treatment, and the risks of refusing treatment.

_____ I have given Dr. Catalano permission to perform a crown on tooth (teeth) # _____

Patient Initials

_____ I understand if any complications occur, I may be referred to a specialist to perform treatment. Patient

Patient Initials

Signature Witness Date _____ Patient or Legal Guardian