ChauLong T Nguyen Dental Corporation
Menlo Park Dental Excellence
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Discussion and Informed Consent for Filling(s)

Patient Name:_____Date:_____

Diagnosis: __Mild __Moderate __Severe Carious Lesions __Fractured Old/New Composite/Amalgam __Tetracycline Stains __ Discolored Teeth __ Mal-Aligned Teeth

Treatment: Use composite resin to restore all current and future fillings, onlays, inlays, crowns, or veneers of the diagnosed teeth in the proposed treatment plan.

I understand that by signing below that I am authorizing the procedure(s) to be performed and I have read and understand the entirety of this form, including the possible risks and complications of the chosen procedure(s) and the available alternatives.

Fillings Important Information: _____*Patient's initials required*

_____Fillings are used to protect a sensitive surface of the tooth, to replace tooth structure, relieve pain, cover an eroded area and fill in a hole or space in the tooth structure.

_____I understand that care must be exercised in chewing after the placement of fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay present at the time of treatment. Following a filling, there may be sensitivity of the teeth that can last for a short period of time. If sensitivity continues, I will notify my dentist, as this can be a sign of more serious problems. During the preparation for a filling, the removal of tooth structure may lead to exposure or trauma to underlying nerve or pulp tissue. Extreme sensitivity or possible abscess often indicates that the pulp did not heal. If that is the case, a root canal treatment or extraction may be required. Because of extreme masticatory (chewing) pressures or other traumatic forces, it is possible for fillings to become dislodged or fracture. The resin-enamel bond that adheres the filling material to the tooth structure can also fail resulting in leakage and recurrent decay.

_____I understand that delaying treatment may cause harm, the dental disease may progress, further damage to teeth may occur and swelling and infection may occur creating additional treatment and associated expenses.

_____In connection with my dental work, **local anesthetic** may be used for pain control during dental procedures. All anesthetics create risks and possible side effects. These include, but are not limited to: swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction and altered sensation that may lead to biting the lip or tongue. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and occasionally may be permanent.

_____**Composite (tooth-colored filling): Resin or white fillings have an advantage of allowing a more "conservative" tooth preparation, can have a strengthening effect on the tooth, have improved aesthetics and virtually blend in with the natural tooth. Risks involved with a composite filling include, but are not limited to, sensitivity of teeth, risks of fracture lines in the tooth structure, necessity for root canal therapy, injury to the nerves, shade variation of the filling, alteration in speech, breakage, dislodgement or bond failure because of pressures or other traumatic forces.**

Check one: __Yes __No I have reviewed the Dental Materials Fact Sheet.

Check the boxes below that apply to you:

CONSENT:

- ❑ I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.
- ❑ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. ChauLong Nguyen to do whatever she deems necessary and advisable under the circumstances.
- ❑ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

OR REFUSAL:

- ❑ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of **alternative treatment and of electing not** to treat my condition.
- ❑ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient (or Patient's Representative) Signature Date

_____ _____

Witness (Staff Member) Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date