Informed Consent for Tooth Fillings

2777 25-10-2023 Date David Grieve Male Patient Nan Gende British 18-09-1979 Nationality : DOB 784-1979-2381743-7

I UNDERSTAND that the treatment of my dentition involving the placement of composite resin fillings which may be more aesthetic in appearance than some of the conventional materials (which have been traditionally used to fill front and back teeth), such as silver amalgam 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.

Eliminate decay, relieve pain, fill in a hole or space in a tooth, cover eroded area, and protect a sensitive surface

CONSEQUENCES OF NOT HAVING WORK DONE or POSTPONING:
May loose the tooth, tooth may fracture, decay will get worse, may result in need for a root canal

ALTERNATIVES:

233IBLE CUMP IN CALIFORMS:
oth may abscess from the filing, may fracture the tooth, tooth can be sensitive to temperature change, or filling may fall out. POSSIBLE COMPLICATIONS:

NECESSITY FOR TWO LABOL LITERARY.

When any type of fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure when any type of fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying adequate to insure sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying

pulp tissue.

Should the pulp not heal, which oftentimes is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may

There is a possibility of injury to the nerves of the lips, Jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which could occur is usually temporary, but in rare instances could be permanent.

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 exhibit a change in shade. The dentist has no control over these factors. Tooth lightening may also result in fillings in front teeth becoming relatively darker.

Due to extreme chewing pressures 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.

Patient's Initials:

I understand that ALL medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of dentistry, provided my

It is the patient's responsibility to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions, including the scheduling and attending all appointments. In the event I wish to discontinue the treatment, I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall

I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in My overall health

I have had the chance to ask questions and express concerns about my dental condition, the treatment options, and my refusal of treatment. The undersigned provider has answered all my questions and addressed all my concerns. I understand the full scope of the situation and am making an informed decision.

The fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Dr. Priyanka Kiran and / or his associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

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I have been given the opportunity to ask questions and give	
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☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

Sign here, only if all of your questions have been answered to your satisfaction

25-10-2023

Date

Patient's name

David Grieve

Signature of Patient Legally authorized Representative

WIDSMERI

25-10-2023

Witness Signature

Date

25-10-2023

Date

Dentist's Signature

rwanka Kiran Ceneral Dentist DHA-00148627-002 DENTISTREE DENTAL CLINIC

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