Informed Consent for Tooth Fillings

File No	:	657			
Patient Name	:	Arhaan Chandwani	**Date**	:	20-03-2024
Nationality	:	Indian	**Gender**	:	Male
Emirates ID No.	:	784-2017-2196982-8	**DOB**	:	03-12-2017

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.

BENEFITS:
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:
Temporary filling

POSSIBLE COMPLICATIONS:
Tooth may abscess from the filing, may fracture the tooth, tooth can be sensitive to temperature change, or filling may fall out.

Necessity for Root Canal Therapy:
When any type of fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure 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 be required.

Injury to the Nerves:
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.

Aesthetics 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 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.

Breakage, dislodgment or bond failure:
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 identity is not revealed

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 health may be affected by my decision.
I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in My overall health stemming from this condition.
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.

Informed Consent:

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. Chahita Lalchandani and / or his associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as Described above.

☐ 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

Arhaan Chandwani		20-03-2024
Patient's name	**Signature of Patient Legally authorized Representative**	**Date**
		20-03-2024
Witness Signature		**Date**
		20-03-2024
Dentist's Signature	Dr. Chahita Lalchandani Pediatric Dentist DENTISTREE DHA-70366191-004 DENTISTREE DENTAL CLINIC	**Date**