

## Informed Consent for Tooth Fillings

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it Name	:	Grzegorz Andrzej Jelen	Date	:	15-12-2021
nationality	:	Polish	Gender	:	Male
tes ID No.	:	784-1986-5362059-5	DOB	:	21-09-1986

I STAND 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 or gold, may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this treatment.

### INDICATIONS:

to relieve 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 :

to lose the tooth, tooth may fracture, decay will get worse, may result in need for a root canal

### ALTERNATIVES:

to have a temporary filling

### POTENTIAL COMPLICATIONS:

to have an abscess from the filling, may fracture the tooth, tooth can be sensitive to temperature change, or filling may fall out.

### Preparation for Root Canal Therapy:

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

to have the pulp not heal, which oftentimes is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

### RISKS to the Nerves:

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

### Color and Appearance:

to have fillings will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the color of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of exposure to fluids, different foods eaten, smoking, etc. may exhibit a change in shade. The dentist has no control over these factors. Tooth whitening may also result in fillings in front teeth becoming relatively darker.

### Chewing, dislodgment or bond failure:

to have 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 inform 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 do not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in My overall health resulting from this condition.

I 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 procedure and am making an informed decision.

### Final Consent:

I have read the above (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 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 associated with this refusal.

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

Grzegorz Andrzej Jelen



15-12

**Patient's name**

**Signature of Patient Legally authorized Representative**

**Date**



15-12-2021

**Witness Signature**

**Date**



15-12-2021

**Dentist's Signature**

**Date**

