Greenwoods™
Dental & Surgical Centres

Informed Consent For Crown Prosthetics

Patient's Name: _____ Date of Birth_____
First *Last*

A crown restoration has been recommended for me on the following tooth (teeth): _____

The crown restoration is necessary because of:

□ Extensive Decay □ Broken Tooth □ Decay around large prior filling □ Changing my bite

□ Cosmetic purposes □ Other:_____

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 that 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 relieve my symptoms.

I understand that 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 the extraction of the tooth.

I understand that I may notice slight changes to my bite. I understand that during and for several days following treatment, I may experience stiff and sore jaws from keeping my mouth open.

I understand there may be injury to my gums around the tooth. I understand that my gums may recede after the completion of my crown restoration. I understand that poor eating habits, oral habits (smoking, fingernail biting, etc.), and poor oral hygiene will negatively affect how long my crown lasts.

I understand that once a crown restoration is started, I must promptly return to have the crown finished. If I fail to return to have the crown completed, I risk decay, the need for root canal treatment, tooth fracture and loss of tooth.

Acknowledgment

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 have discussed my treatment with my dentist 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, the risks of refusing treatment, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I understand the risks and elect to have this procedure performed by Dr._____. I understand that if any unexpected difficulties occur during treatment, I may be referred to a prosthodontist for further restorative care of this tooth.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist