INFORMED CONSENT FOR RESTORATIVE AND PROSTHODONTICS

A. IDENTIFICATION

I, _____ willingly agree to the following procedure:
(Print your full name)

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. Such complications may involve, but are not inclusive to:

- Infection, bleeding, numbness, tissue tenderness, teeth sensitivity, changes in tissue appearance, loss of tissue height, exposed roots, perforation of the tooth root, loss of teeth, damage to adjacent structures, jaw or joint soreness (TMD), damage to existing restorations, changes in fit of partials or dentures and tooth pulp damage or necrosis.

I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand that a perfect color match to my existing teeth is impossible and that everything possible will be done to ensure the closest match. I understand the nature of the operation or procedure to be:

- Preventing or taking out decay, repairing, reinforcing or changing the esthetics of my teeth utilizing fillings, crowns, veneers or bridges.
- The teeth that these procedures will be performed on are located in the area of:
  Upper / Lower *(Circle appropriate one(s))*
  Front / Back *(Circle appropriate one(s))*
  Left / Center / Right *(Circle appropriate one(s))*

This procedure will be performed under the direction of **Dr._____.**

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the above-named dental facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the above named facility. I understand that with the administration of such anesthesia numbness will occur to my face and lips. During this time care must be taken not to aggressively touch these areas and care must be taken when eating or trauma will result to these structures.

C. SIGNATURES

1. COUNSELING DENTIST/PROFESSIONAL: I have counseled this patient as to the nature of the proposed procedure(s), attendant risk involved, and expected results, as described above.

Signature of Counseling Dentist/Professional	**Date and Time**

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, described above.

Signature of Patient or Legal Guardian	**Date and Time**
Signature of Witness	**Date and Time**