Consent to Treatment - Fillings

This form can be filled out on a computer, printed, then hand signed.

Legal First Name	Legal Middle Name / Initial	Legal Last Name	Today's Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ **1. FILLINGS** **TOOTH #** _____

I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during tooth preparation. I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that If my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns. Finally, I also understand that I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred will be my responsibility.

_____ **2. DRUGS and MEDICATIONS**

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting. I have informed the doctor of any known allergies that I have.

_____ **3. RISKS of DENTAL ANESTHESIA**

I understand that pain, bruising and l temporary or sometimes permanent numbness in lips, cheeks, tongue and/or associated facial structures can occur with local anesthesia. Almost all of these cases resolve themselves in a few weeks. About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possible treatment may be needed if the symptoms do not resolve on their own.

_____ **4. RISKS of WORSENING CONDITIONS**

Due to the unique differences in each patient's oral cavity and oral hygiene abilities there is always a risk for relapse, recurrence, and/or failure of restorations. I understand that it is impossible to predict if and how fast my condition would worsen if untreated, but it is the doctor's opinion that worsening of the condition(s) would occur sooner without the recommended treatment.

_____ **5. CHANGE in TREATMENT PLAN**

I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during the initial examination. I authorize my doctor to use professional judgment to provide appropriate care and understand that the fee proposed is subject to change, depending upon those unforeseen or undiagnosed conditions that may only become apparent once treatment has begun.

Please note: Monies paid for treatments and services already rendered cannot be refunded or exchanged for additional work. Also, should complications arise during treatment, Dr. Tan reserves the right to refer the patient to a specialist and any fees for specialist care will be the sole responsibility of the patient.

CONSENT: My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment.

Patient's or Guardian's Signature (please sign in pen)	Today's Date
Witness' Signature	Today's Date

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