North Bethesda Dental Associates

RESTORATIVE TREATMENT
INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for elective dental restorative treatment. Each item should be initialed after the patients (and/or their parents or guardians) have the opportunity for discussion and questions.

_____ 1. **I, THE UNDERSIGNED, CONSENT TO Dr. Tilkin, his/her partners, associates, dental assistants and/or staff performing on me the outlined Restorative Treatment Plan** (*as outlined on the "Treatment Form" that has been provided to me*).

_____ 2. **I accept and understand that the procedure(s)** *is/are elective in nature and not treatment for any dental disease.*

_____ 3. **I accept and understand that although Dr. Tilkin will make every effort to the esthetics of my smile, there are limitations due to function, color, extent of inherent staining, shape and/or placement of the original teeth.**

_____ 4. **I accept and understand that restorative treatment results are subjective**; thus, *the outcome of my Restorative Treatment Plan may not completely meet my expectations.*

_____ 5. **I accept and understand that the alternatives to the Restorative Treatment Plan, which have been fully discussed with me, include but are not exclusive of:**

_____ **a. Direct/indirect resin fillings, direct/indirect alloy fillings, direct/indirect gold fillings, dental implants, bridges, partial/full dentures.**

_____ **b. No Treatment.**

_____ 6. ***Each option has been fully explained to me with its' benefits, risks, pros, cons, and approximate investment cost.*** I accept and understand that there are ***risks and limitations*** to all procedures. For this restorative treatment these risks and limitations include, but are not exclusive of:

_____ *a. Hot, cold and/or biting sensitivity*
_____ *b. a "high spot" in bite may develop after the numbness has worn off*
_____ *c. the nerve of the tooth could become injured*
_____ *d. Need for elective root canal therapy* ***(at additional cost)***
_____ *e. Chipping of restorations*
_____ *f. Change in speech*
_____ *g. Change in appearance*

_____ 7. **I accept and understand that I may be wearing temporary crown(s),** which may come off easily, and that I must be careful to ensure that it/they is/are kept on until the permanent crown(s) is/are delivered.

_____ 8. **I accept and understand that the final opportunity to make a change in my new crown, bridge or cap** (including shape, fit, size and color) is before cementation.

_____ 9. I have had the opportunity **to discuss** the Restorative Treatment Plan, and have had an opportunity **to ask questions**, and am fully satisfied with the answers received.

_____ 10. **If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.**

_____ 11. **I accept and understand that, as with any medical or dental procedure, there are no guarantees as to the longevity of the work performed. I also accept and understand that** *the Restorative Treatment Plan does not contain any warranty.*

_____ 12. I accept and understand that I play a major role in the maintenance of my teeth and restorations.

_____ 13. **I agree to maintain good oral hygiene and keep regular dental check-ups and cleaning appointments with Dr. Tilkin, at least every 6 months.**

_____ 14. I understand that photographs may be taken of the procedures, and hereby give my consent to those photographs being taken, as well as my consent to before and after photographs being taken. I also understand and consent to those photographs being used for and in documentation, diagnosis and treatment planning.

Patient's Signature (or Parent/Guardian):_____ **Date:** _____

Patient's (or Parent/Guardian's) Identification: _____

Witness' Name:_____ **Witness' Signature:**_____ **Date:**_____

Doctor's Signature: _____ **Date:** _____