



Novato Family Dental Care

BE TREATED LIKE FAMILY

INFORMED CONSENT FOR CROWNS

Patient Name: _____

Date: _____

Diagnosis: _____

FACTS FOR CONSIDERATION

- _____ Treatment involves restoring damaged areas of the tooth above and below the gumline with a crown.
- _____ Restoration of a tooth with a crown requires two phases: 1) preparation of the tooth, an impression sent to the lab, construction and temporary cementation of a temporary crown; and later, 2) removal of the temporary crown, adjustment, and cementation of the permanent crown after esthetics and function have been verified and accepted.
- _____ Once a temporary crown has been placed, it is essential to return to have the permanent crown placed as the temporary crown is not intended to function as well as the permanent crown. Failing to replace the temporary crown with the permanent crown could lead to decay, gum disease, infections, problems with your bite, and loss of the tooth.

BENEFITS OF CROWNS *(not limited to the following)*

- _____ A crown is typically used to strengthen a tooth damaged by decay, fracture, or previous restorations. It can also serve to protect a tooth that has had root canal treatment and improve the way your other teeth fit together.
- _____ Crowns are used for the purpose of improving the appearance of damaged, discolored, misshapen, malaligned, or poorly spaced teeth.

RISKS OF CROWNS *(not limited to the following)*

I understand that preparing a damaged tooth for a crown may further irritate the nerve tissue (called the pulp) in the center of the tooth, leaving my tooth feeling sensitive to heat, cold, or pressure. Such sensitive teeth may require additional treatment including endodontic or root canal treatment.

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. This can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise.

I understand that a crown may alter the way my teeth fit together and make my jaw joint feel sore. This may require adjusting my bite by altering the biting surface of the crown or adjacent teeth.

I understand that the edge of a crown is usually near the gumline, which is in an area prone to gum irritation, infection, or decay. Proper brushing and flossing at home, a healthy diet, and regular professional cleanings are some preventative measures essential to helping control these problems.

I understand there is a risk of aspirating or swallowing the crown during treatment.

I understand that I may receive a local anesthetic and/or other medication. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the normal chance of swallowing foreign objects during treatment.

**INFORMED CONSENT
FOR CROWNS - CONTINUED**

_____ I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are: _____

_____ I understand that every reasonable effort will be made to ensure the success of my treatment. There is a risk that the procedure will not save the tooth.

CONSEQUENCES IF NO TREATMENT IS ADMINISTERED *(not limited to the following)*

I understand that if no treatment is performed, I may continue to experience symptoms which may increase in severity, and the cosmetic appearance of my teeth may continue to deteriorate.

ALTERNATIVES TO CROWNS *(not limited to the following)*

I understand that depending on the reason I have a crown placed, alternatives may exist. I have asked my dentist about them and their respective expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs. Alternatives discussed: _____

CONSENT

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

- 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 understand the potential consequences associated with this refusal

Patient's Signature: _____

Date: _____

I attest that I have discussed the risks, benefits, consequences, and alternatives of crowns with _____
(patient's name) who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Dentist's Signature _____

Date _____

Witness' Signature _____

Date _____