## INFORMED CONSENT

The intent of this document is to inform you and review the possibilities that exist as potential problems when undergoing dental restorative and prosthodontic treatment. Many of the problems or conditions mentioned occur only occasionally or rarely. There may be other inherent risks not discussed in this document. You should be aware that problems can occur, and that every effort will be made to treat the conditions that develop or we will refer you to the appropriate health care professional.

The practice of dentistry is not an exact science and therefore, we cannot guarantee results. Please understand that no one can promise that any treatment or dental procedure will be successful or that any risk, complication or injury will not occur.

You should understand that unforeseen conditions or circumstances might arise during the course of treatment. The following information is routine for anyone considering restorative and prosthodontic treatment in our office. While recognizing the benefits of a pleasing smile and well-functioning teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to stop treatment, but should be considered in making a decision. As in all other healing arts, results cannot be guaranteed. Your material sensitivities are being taken into consideration.

## INITIAL DIAGNOSTIC PROCEDURES:

Radiographs and a complete examination were performed to assess your current dental health. Cone beam CT's of your jaw joints were made to determine the level of pathology with the joints. Furthermore, a 3- dimensional airway assessment was made. A periodontal (gums) diagnosis was made and expressed to you. Your dental concerns and problems were discussed. **Models (moulds) of your teeth were made and a diagnostic wax-up will also be made to simulate the end result.**

## TREATMENT RECOMMENDATIONS:

Are based on information gained from the initial diagnostic procedures, previous experience and may vary for similar situations. Our goal is to assist you in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. As needed, consultation with other specialists will be made. We will also inform you of the likely dental prognosis of these treatment plans and a dental prognosis if no treatment is initiated at this time.

## AESTHETIC CONSIDERATIONS:

It is our intent to contribute all of our technical and artistic capabilities to help you achieve your aesthetic expectations and to incorporate these factors in your final dental restorations. Your input is critical to the success of the final restorations. You are encouraged to bring with you any friend or relative during the final aesthetic consultations. After your approval, the restorations will be finalized, after which only very minor changes can be made. Some changes in appearance may be beyond the capabilities of restorative and prosthetic dentistry and may require orthodontics, oral-maxillofacial surgery, plastic surgery or other adjunctive measures.

## YOUR TREATMENT:

Your treatment will consist of crowns on all remaining teeth (25). Dental crowns are restorations that cover up or cap teeth allowing us to restore them to their natural size, shape or colour. The crown not only improves function and appearance, but can also strengthen a tooth that might otherwise be lost. In some cases a crown covering the entire tooth may not be necessary, and an onlay or porcelain laminate (veneer) is recommended. For this document, the term crown will include inlays, onlays and porcelain laminates.

## ROOT CANAL TREATMENT:

There is a 6-8% chance that any tooth that is prepared will need a root canal. In some cases this can be determined before treatment and in some cases only after final cementation. A root canal replaces the dental pulp, the inner most part of the tooth. This treatment becomes necessary when the pulp is irreversibly injured or infected from the cumulative effects of cavities, fillings or cracks in the teeth and occurs approximately 6-8% of the time. Preparing teeth for crowns requires removal of old filling material, decay and damaged tooth structure. Buildup of loss of tooth structure (Cores) may be required. This will be determined at the time of tooth preparation.

## PORCELAIN FRACTURE:

Porcelain is the most suitable material for the aesthetic replacement of tooth enamel. Because porcelain is a “glass-like” substance, it can break. However, the strength of dental porcelain is similar to dental enamel, and the force necessary to fracture dental porcelain would usually fracture natural tooth enamel. Some fractures can be repaired others need to be replaced. If there is a choice of materials i.e. porcelain, porcelain and metal or gold, this will be reviewed with you.

## BITE PROBLEMS

You expressed a concern about your bite “only my front teeth are touching, there is pressure, doesn’t feel right, I snore”. After assessment of your jaw and the x-rays, it has been determined that there is a pre-existing problem with your bite and jaw. We will start treatment with day and night orthotics to stabilize your jaw and bite prior to starting any restorative treatment (crowns). The CT’s also demonstrated that your airway was improved with the bite registration. A sleep study is indicated to allow a proper diagnosis of your sleep problems.

## INFORMED CONSENT AND AUTHORIZATION

I certify that I have read and understand the above pages of the Informed Consent, which outlines the general treatment considerations as well as the potential problems and complications of restorative/prosthodontic treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document. I understand that during and following the contemplated procedure, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials or care, if it is felt this is for my best interest. I consent that photographs of the procedure may be shown for teaching purposes.

Dr. Name:

Address:

Signed:

Dated:

Witness