

North Island Dental Arts
1613 Hillside Ave
New Hyde Park, NY 11040
516-616-4800 Tel
516-616-0364 Fax

Doctor for rendering treatment:

Patient:

Tooth#

Informed Consent for Fillings, Restorations, & Core-Build up Treatment

Dental core build-up fillings are restorations that fill and restore the crown portion of the tooth restoring it to their natural size, shape and very often the natural color. A "core build-up" not only helps with appearance, but can strengthen a tooth as well.

A crown covering the entire tooth is always necessary following the successful placement of the core build up restoration. Dental crowns and bridges are made of porcelain, resins, metal or acrylic and may or may not have an inner layer of metal. Some may be made of metal alone.

As with all procedures, there are certain potential problems associated with crowns and bridges. These include, but are not limited to:

- The potential need for root canal therapy. The cumulative effects of cavities, fillings and cracks in the teeth may necessitate a root canal. The need for a root canal may become apparent during or following a core build up, a crown preparation or after a crown (inlay, onlay, or laminate) is made.
- Periodontal (gum) disease can occur at any age, with or without core build-up crowns and bridges. Generally speaking core build-ups, crowns and bridges do not create or prevent gum disease. However, meticulous home preventative care is required to prevent this problem from occurring. Gum recession is a typical response to a crown and the edge of the crown may become visible over time.
- Fractures to the tooth or to the dental materials may occur after placement. Small fractures may be repaired; large fractures may require a new crown or bridge. Repairs and replacements are at additional cost to the patient.
- Dark lines at the gum line may appear on core build-ups, crowns or fixed bridges lined with metal. This is the metal edge of the crown. If the gum recedes after placement, this metal will show. Sometimes this can be corrected, other times a new crown or bridge might be needed.
- Recurrent tooth decay can occur after placement. This may be corrected with a filling or a new crown or bridge might be needed at additional cost to the patient.
- Food impaction may occur under a bridge-this may be an unavoidable condition. Meticulous home care is required.
- Temporomandibular Joint Dysfunction may occur due to changes in the bite following crowns and bridges. This can usually be corrected, but in rare occasions may cause symptoms requiring extensive treatment. Soreness, swelling, bruising, and restricted mouth and/or damage to the jaw joints (TMJ) which may be permanent or temporary
- Swelling, bruising, sensitivity and pain. Post-operative infections and/or bleeding requiring more treatment by Dr. Bee and/or other health care providers and specialists
- Damage to nerves resulting in temporary or permanent numbness, tingling and loss of function of the lip, chin, tongue, or other area
- Damage to adjacent teeth, fillings, restorations, bridges and crowns.
- Drug reactions, allergic reactions, adverse reaction to anesthetics and/or medicines, nausea and side effects

I have read and understand the preceding, and have been completely informed and understand the recommended treatment, the professional fees involved, the risks of treatment, any and/or all alternatives and risks of these alternatives, including the consequences of doing nothing. I have declined a referral to and treatment by a specialist in fixed prosthodontics. I have had all of my questions answered, and no guarantees or warranties have been offered or implied. I have been given and understand the verbal and written post-operative instructions. I hereby consent to local anesthetic and the recommended treatment. I understand that Dr. Bee may discover other or different procedures than those planned. I authorize him to perform such other procedures, as he deems necessary in his professional judgment.

I am having a crown performed today _____ I Decline a crown procedure to protect this tooth _____

Patient Name (Printed): _____

Patient Signature: _____ Date _____

Witness: _____ Date _____