SKHDENTISTRY
519-745-1821

CROWN CONSENT

I am being provided with this information and consent form so I may better understand the treatment recommended for me. I understand that I may ask any questions I wish, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Reasons for Crown Restorations
A crown restoration has been recommended for me on the following tooth (teeth):_____

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history.
The crown restoration is necessary because of:
Extensive decay ___ Broken Tooth___ Decay around large prior filling___ Changing my bite___
Too large for regular filling___ Large filling, cusps compromised ___ Cosmetic purposes___
Following Root Canal treatment___ Other:_____

Timeline of Crown Restorations
Crowns usually require at least two visits to complete treatment. After the first visit, a plastic temporary crown is held on the tooth with temporary cement while the crown restoration is being made by a dental laboratory. This takes approximately **3 weeks** but can vary. It is important to return for the cementation of the new crown as soon as it is ready in order to reduce the chance of new tooth decay or other problems.

Benefits of Crown Restorations
The intended benefit of a crown restoration is to replace missing natural tooth structure and restore the tooth to normal function and/or improve the shape and color (cosmetics) of the tooth (teeth). The crown restoration also may relieve current symptoms of discomfort I may be having.
The prognosis, or likelihood of success, of this treatment is Excellent/ Fair/ Questionable
My crown restoration(s) is/are estimated to cost $_____

Alternatives to Crown Restorations
Depending on my diagnosis, there may or may not be alternatives to a crown restoration that involve other types of dental care. I understand that possible alternatives to crown restorations may be:

- Other restorative alternatives, such as onlay, inlay, veneer or a composite filling.
- Extraction. I may decide to have my tooth/teeth removed. The extracted tooth usually requires replacement.
- No treatment. I may decide to have no treatment performed at all. If I decide upon no treatment, my condition may worsen and I may risk serious personal injury, including severe pain; localized infection; loss of this tooth and possibly other teeth; severe swelling; and/or a severe (spreading) infection.

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Risks of Crown Restorations

- I understand that the nerve inside my tooth may be irritated by treatment and I may experience pain or discomfort during and/or after treatment. My tooth may become more sensitive to hot and cold liquids and foods. I understand that **root canal treatment may become necessary** at any time during or after treatment and may not be avoidable. Any root canal treatment that is needed will be paid at my expense. My dentist has discussed the rationale for a preventative root canal treatment.
- A crown restoration may not relieve my symptoms.
- Once prior fillings and decay are removed, it may reveal a more severe condition of my tooth. This condition **may require periodontal (gum) surgery** to uncover more of the tooth, may require root canal treatment, or may instead **require the extraction of the tooth**. I understand that these procedures will result in an additional expense, and may need to be performed by a specialist at another office.
- There may be slight changes in my bite. I understand that during and for several days following treatment, I may experience stiff and sore jaws from keeping my mouth open. **I will inform my dentist** if I experience any of these symptoms.
- My gums may recede after the completion of my crown restoration.
- Poor eating habits, oral habits (smoking, fingernail biting, clenching and grinding, etc.), and poor oral hygiene will negatively affect how long my crown lasts.
- Other foreseeable risks not stated above include:_____

I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about,
Including_____

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment. I have discussed my treatment with my dentist and have been given an opportunity to ask questions and have them fully answered.

Patient Signature:_____ Date:_____

Witness Signature:_____