CONSENT FOR DENTAL CROWN

You have been recommended one or more crowns because your tooth/teeth

Has a crack in it
Has a large filling that is failing
Has had or needs root canal treatment
Is worn down
Is broken down
Other:_____

A crown procedure requires at least 2 appointments. The first appointment will take about an hour and half (per tooth) and this is when most of the work is done. An impression will be taken and a temporary will be made. The impression is then sent to a lab to fabricate the crown. At the second appointment the crown is cemented in.

The crown can be made of gold, porcelain only or porcelain with a metal base. Gold is the most bio-compatible material however it is not white in colour. Porcelain is white in colour however it has the highest chance of cracking. The third option is a porcelain crown with a gold sub-structure. This is the best choice for back teeth where a patient desires a white crown that does not fracture easily.

After the crown procedure is started or completed:

- The tooth may become sensitive or existing sensitivity can become worse. This may indicate that the tooth needs root canal treatment. If root canal treatment is needed after the crown is cemented, a hole will have to be made through the crown or the crown may need to be replaced;
- Your bite may be altered. We may need to make minor changes on the surface of the crown or of adjacent or opposing teeth to bring the bite as close to the way it was as possible. Sometimes shifting of the jaw joint can cause the bite to feel 'off';
- The look of the crown may not meet your expectations. All efforts are made to get a pleasing result;
- At the second fitting appointment, the crown may not 'fit' accurately. We may need to take new impressions and/or send it back to the lab to modify the crown. In this case you will need to come back for another fitting appointment;
- A crown can last for many years and this depends on several factors including hygiene, diet, etc. Most insurance companies will pay for a new crown after 5 years. However a crown can fracture or unseat at anytime;
- After we start the treatment to make the crown, we may have to change the treatment plan due to unforeseen circumstances. This could include a crack that was not seen on the x-ray or clinically or the extent of decay is more than we expected. In this case the tooth may need to be extracted;
- It is important to wear a night guard after your crown if you have been so advised by us and if you are known to clench and grind your teeth. Failure to do this may cause fracture of the crown and will not be guaranteed by our office.

Patient's name: _____ Age: _____
I hereby give consent to perform the following procedure for myself or my dependent

_____ _____
Date Signature of Parent/Guardian

Dr. Lynn Lamont
300 Crown St.
Saint John NB E2L 2Y4

Endodontic Information and Consent Form

Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics and Medications

While serious complications associated with root canal therapy are very rare, we would like our patients to be informed about the various procedures in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which might otherwise need to be removed. Root canal therapy is completed in one or more appointments. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The objectives of this treatment are: to relieve pain and infection, if present, remove the diseased pulp tissue, clean, disinfect and fill the root canals. Radiographs and local anesthetics will be required during the treatment. Antibiotics and analgesics may also be needed. The following possible risks may occur at any time during endodontic treatment:

Risks: Complications resulting from, but not limited to, the use of dental instruments, drugs, sedation, medicines, anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensations in the lip, tongue, chin, gum, cheeks and teeth, which is transient but on occasions may be permanent reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

Risks More Specific to Endodontic Therapy: The risks include the possibility of instruments broken within the canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to the canals and cracked teeth. During treatment complications may be discovered which make treatment impossible or which may require dental surgery. Such complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, and splits or fractures of the teeth. Cases started in other offices or re-treatment cases are usually more difficult and may have a different outcome than expected under normal conditions.

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Other Treatment Choices: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infections to other areas.

CONSENT

I, the undersigned, being the patient (parent or guardian of above minor patient), acknowledge that I have read this form and consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require re-treatment, surgery or extraction at an additional fee.

Patient's Name: _____ Age:_____

Date:_____ _____

Signature of Patient/Guardian

OralID
Shine Light. Save Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

☐ Yes, I request that your staff perform an examination with the OralID.

_____	_____	_____
Signature	Name	Date

☐ No, I prefer to not have this examination at this visit.

_____	_____	_____
Signature	Name	Date

INFORMED CONSENT FORM
FOR ORAL AND MAXILLOFACIAL SURGERY
AND ANESTHESIA

Dear Patient:

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the risks and hazards. The disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so we may give an informed consent to the procedure. Please be assured that we will do our best at all times to make healing as rapid and trouble-free as possible.

POSSIBLE COMPLICATIONS *(may be variable in occurrence):*

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

_____ **ALL SURGERIES:**

1. Soreness, pain, swelling, bruising, and restricted mouth opening during healing sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exists.
2. Bleeding, usually controllable, but may be prolonged and required additional care.
3. Drug reactions or allergies.
4. Infection; possibly requiring additional care, including hospitalization and additional surgery.
5. Stretching or cracking at the corners of the mouth.

_____ **ALL TOOTH EXTRACTIONS:**

1. Dry socket (delayed healing) causing discomfort a few days after extraction requiring further care.
2. Damage to adjacent teeth or fillings.
3. Sharp ridges or bone splinters; may require additional surgery to smooth area.
4. Portions of tooth remaining - sometimes fine root tips break off and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus cavity.

_____ **UPPER TEETH:**

1. SINUS INVOLVEMENT: Due to closeness of the roots of upper back teeth to the sinus or from a root teeth being displaced into the sinus, a possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

_____ **LOWER TEETH:**

2. NUMBNESS: Due to proximity of tooth roots (especially wisdom teeth) and other surgical sites to the nerves, it is possible to loose function of nerves following the removal of the tooth or surgery in the area. The lip, chin, teeth, gums, or tongue could thus feel numb (resembling local anesthetic injection). There may also be pain, loss of taste, and change in speech. This could remain for days, weeks, or possibly, permanently.
3. JAW FRACTURE: While quite rare, it is possible in difficult or deeply impacted teeth and usually requires additional treatment, including surgery and hospitalization.

_____ ANESTHESIA:

1. LOCAL ANESTHESIA: Certain possible risks exists that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected reactions which could result in heart attacks, stroke, brain damage, and/or death.
2. INTRAVENOUS OR GENERAL ANESTHESIA: Certain possible risk exists that, although uncommon, may include nausea, pain, swelling, inflammation, and/or bruising at the injection site.

Rare complications include nerve or blood vessel injury (phlebitis) in the arm or hand and allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage, and/or death.

If I am having intravenous sedation or general anesthesia, I understand that I have NOT HAD ANY FOOD OR DRINK FOR SIX HOURS before my appointment. To do otherwise MAY BE LIFE-THREATENING! I agree not to drive myself home for the next 24 hours and will have a responsible adult accompany me.

ALTERNATIVE TREATMENT OPTIONS:_____

PATIENT NAME:_____

I hereby authorize Dr. _____ and staff to perform the following procedures:

_____

_____ and to administer an anesthetic. I understand the doctor may discover other or different conditions that may require additional or different procedures than those planned. I authorize him/her to perform such other procedures as he/she deems necessary in his/her professional judgment in order to complete my surgery.

I have discussed my past medical history with my doctor and disclosed all diseases and medications and drug use. I agree not to operate vehicles or hazardous machinery while taking prescription narcotic pain medications.

I have received written postoperative instructions regarding home care, including emergency after hour phone numbers.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor or his/her designated agent as soon as possible.

I have read and discussed the preceding with the doctor and believe I have been given sufficient information to give my consent to the planned surgery. No warrantee or guarantee has been made as to the results or cure. I certify that I speak, read, and write English and have read and fully understand this consent form for surgery; or if do not, I have had someone translate so that I can understand the consent form. All blanks were filled in prior to my initials and signature.

_____

Patient's (or legal guardian's) signature Date

_____

Witness signature Date

_____

Doctor's signature Date