PATIENT: ________________________________
DATE: ________________________________

TOOTH COLOURED INLAY/ONLAY RESTORATION INFORMED CONSENT

You have been informed that you require restoration(s) on the following teeth:

UPPER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	LOWER LEFT

PURPOSE OF THE TREATMENT:

This procedure is deemed necessary because :

❒ New Cavity Present (New Caries)
❒ Old Amalgam Fractured or Badly Broken Down
❒ Other ____________________
❒ Fractured Tooth
❒ Recurrent Caries
❒ Worn Tooth

A CONCEPT RESTORATION PROCEDURE REQUIRES **TWO (2)** APPOINTMENTS:

The **first** appointment will require 60 minutes of your time. It consists of :
Anesthesia (freezing)
Tooth Preparation
Tooth Isolation
Impression(s)
Shade Selection for Restoration
Fabrication of Temporary

The **second** appointment will require 60 minutes of your time. It consists of:
Anaesthesia (if necessary)
Removal of Temporary
Try-in of Restoration
Preparation of Restoration
Preparation of Tooth for Bonding
Bonding of Permanent Restoration
Bite Adjustments, Fine Contouring, and Polishing

BENEFITS OF THE TREATMENT:

Restorations replace diseased, missing, or defective tooth structure, and support or strengthen that which is remaining. They can improve chewing, allow proper speech, assist in the maintenance of healthy supporting tissue, and enhance appearance.

RISKS OF THE TREATMENT:

Gums or tissues involved in the anaesthetic injection may be sore for several days following treatment. Swelling of the tissues around the injection site is possible and can be treated by applying pressure and cold (ie. ice packs) the day of treatment to the area of swelling for a minimum of 1-2 minutes. In addition, if freezing involves the lower jaws, there may be difficulty opening the jaw for the first few days. The soreness and stiffness will dissipate with time but warm salt water rinses or moist heat on the side of treatment will facilitate healing. Transient facial paralysis is a rare possibility upon anaesthetic injection,

but it will almost always resolve itself without any future consequences.

Removal of tooth structure when treating deep cavities may irritate the pulp of the tooth, and a root canal treatment may be required. Although rare, this treatment may be needed before, during, or after treatment to prevent discomfort or infection.

Receding gums, a common aging process, may on occasion be accelerated by restorative procedures. If the root structure exposed by receding gums is sensitive, these areas may require application of desensitizing agents.

Sometimes it is necessary to adjust the shape of teeth other than those being restored. Joints, muscles, and ligaments of the jaw on occasion react adversely to even minor changes to the biting surfaces of teeth. As a result, and in order to prevent any discomfort, minor reshaping may be necessary.

ALTERNATIVES TO TREATMENT:

If the life expectancy of a tooth is questionable, extraction may be an option. Should decayed teeth that can be restored not be treated, the decay process will continue and will result in further loss of tooth structure, pain, and infection.

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment. I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material. I have been given the opportunity to ask questions.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment.

I consent to the taking of photographs throughout the entire treatment procedure. Should these photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE ______________________________

LAB FEE (approx.) ______________________________

TOTAL FEE (approx.) ______________________________

Dated at London, Ontario, this ________ day of ______________________________

SIGNED: ______________________________
PATIENT

WITNESS: SIGNED: ______________________________
Parent, Guardian or Nearest Kin if patient
is under the age of 18