PROSTHODONTIC INFORMED CONSENT

This document is intended to inform you of some of the myriad of possibilities that exist as potential problems with dental treatment. Most complications mentioned occur rarely. There are potential risks that are not discussed in this document. Please be aware that if these complications occur, effort will be made to treat the conditions that develop and/or we will refer you to an appropriate health care professional. You are encouraged to actively ask questions specific to your care, your understanding is important to treatment.

Dentistry is not an exact science and therefore, reputable practitioners cannot guarantee results. Understand that no one can promise any treatment or procedure will be successful or that any risk, complication or injury will not occur.

You should understand that unforeseen conditions or circumstances may arise during treatment. The following information is provided to all patients considering treatment. Dentistry, like any treatment, has inherent risk and limitations. These potential problems are seldom enough to make treatment ill-advised but should be recognized prior to making a decision (informed consent).

REFERRAL TO OTHER SPECIALISTS:
Dental restorative and prosthodontic treatment often require treatment with other offices specialties such as:

- *Periodontics:* Treatment of gum tissue and implant placement
- *Endodontics:* Root canal treatment
- *Orthodontics:* Straightening of teeth
- *Oral Surgery:* Extractions, jaw surgery, jaw augmentation and implant placement.
- ***Fees for treatments in other offices are quoted by that office.*

TREATMENT RECOMMENDATIONS: Are based on information gained from initial diagnostic procedures and previous experience and may vary for seemingly similar situations. Therefore, second opinions are often appropriate. The goal of treatment is to assist you in attaining optimum dental health and appearance. We will discuss with you the options for treatment. Recommendation for optimal treatment plans as well as reasonable alternative treatment plans when appropriate will be provided along with prognosis of each and consequence of no treatment. Where clinical challenges are significant, recommendations may be made only after consultation with specialists.

ESTHETIC CONSIDERATIONS: Appearance is highly subjective and personal. We intend to contribute our technical and artistic capabilities to help you achieve your appearance expectations and to incorporate these in your final dental restorations. You are asked to provide your input during treatment, and an effort will be made to incorporate your wishes in harmony with the functional and physiological requirements of the restorations. You are encouraged to bring with you any friend or relative during the final esthetic consultations. You are encouraged to look at them in different lights prior to providing your consent / approval. Prosthetic teeth are not natural teeth. They can appear slightly different depending on the incident light (metamerism). Perfect color match in all lighting conditions is not possible. After approval, fixed restorations will be placed. After placement, little shape change and no color changes are possible. Some changes in appearance may be beyond the capabilities of prosthetic dentistry and may require orthodontics, oral-maxillofacial surgery, plastic surgery, or other adjunctive measures.

DIRECT RESTORATIONS

COMPOSITE / WHITE FILLINGS: These materials can be used to replace decayed tooth structure and to change the shape or color of teeth. These materials do not require significant preparation to the tooth and are attached with adhesive. As this procedure is performed in the mouth with no laboratory component, there is more variability in the final appearance. Composites are less durable than most laboratory fabricated restorations (crowns, bridges or veneers) and experience greater wear, marginal staining and color change, especially in the presence of red wine, coffee tea, cola, turmeric and curry and tobacco. White fillings do not reinforce teeth. Teeth with large fillings are recommended to have crowns/onlays placed to reduce the risk of fracture or crack propagation.

FIXED PROSTHETICS

CROWNS/ FIXED BRIDGES/ ONLAYS/ VENEERS: Dental crowns cover up or cap teeth, restoring them to their natural size, shape or color. Crowns do not strengthen teeth; they can however reduce the risk of tooth fracture. At times conservative bonded restorations like veneers (visible surface only), onlays or inlays (chewing surfaces only) are possible. For discussion in this document, the term *crown* will include inlays, onlays and porcelain laminate (veneer).

A fixed bridge is designed to replace teeth that have been lost. Aside from the obvious effects of missing teeth on personal appearance and mastication, there are other concerns. The normal pressure of chewing and stress can cause the remaining teeth to shift out of alignment, resulting in malocclusion and periodontal (gum) problems. Dental crowns and fixed bridges are made of porcelain for natural appearance and may contain an inner layer of metal alloy or zirconia ceramic for strength. Dental crowns and fixed bridges are attached to teeth with cement and with current materials they cannot be removed without cutting them from the underlying tooth.

POTENTIAL PROBLEMS WITH FIXED PROSTHETICS *Crown and fixed* bridges *are used to treat problems of decay, fractured teeth, malocclusion and to protect teeth from fracture. Dental restorations are replacements for natural tooth structure and potential problems exist.*

- **PERIODONTAL (GUM AND BONE) DISEASE:** Periodontal disease can occur at any age, with or without crowns or fixed bridges. Well-designed crowns and bridges aid in prevention of gum disease, as does good oral hygiene, regular professional cleanings, dental examination, a healthy diet, and good general health.
- **TOOTH ROOT MOBILITY:** Tooth roots may be mobile if they are not strong enough to withstand the forces on natural teeth on crowns and fixed bridges. This occurs when gum tissue and bone around the roots have severely receded or the biting forces are unusually high.
- **ROOT CANAL TREATMENT:** Restoration of a damaged tooth with a crown can be used to protect the tooth from fracture. However, the need for a root canal may not become apparent until after the crown has been placed. This treatment becomes necessary when the pulp is irreversibly injured or infected from the cumulative effects of cavities, fillings or cracks in the teeth. Approximately 6% of teeth prepared for crowns will require root canal treatment thereafter. In some instances, the longevity of the crown/ bridgework may be compromised, and replacement of the dental crown or fixed bridge will be necessary.
- **TOOTH PREPARATION:** Preparing teeth for dental crowns or fixed bridges require removal of old fillings, decay and unsound tooth structure. In addition, the removal of some sound tooth structure is often required to make room for the porcelain or metal.
- **PROVISIONAL (TEMPORARY) RESTORATIONS:** Provisional crowns and fixed bridges are used to protect the teeth and provide a satisfactory appearance while crowns bridges are being fabricated. They are made of acrylic or resin-composite that is not as strong as the definitive metal or ceramics. Provisionals have some flex, this combined with weak cement allows for removal. Therefore, it is important to minimize chewing stresses on provisional restoration(s) to reduce fracture or dislodgement. If this does occur, the provisional restoration(s) must be repaired and/or re-cemented. Failure to wear/ replace dislodged provisionals can result in shifting of tooth positions which may result in the newly made crowns not fitting.
- **PORCELAIN FRACTURES:** Porcelain is the material for esthetic replacement of tooth enamel. Because porcelain is a “glass-like” substance, it can break just like teeth and the force required is similar. Small porcelain fractures can at times be repaired or polished, while larger fractures often require a new restoration. Newer ceramics called “Monolithics” have largely eliminated this problem.
- **DARK LINES AT GUM TISSUE:** Dark lines may appear at the gum line of porcelain crowns and fixed bridges. The dark line is either the metal part of the crown which is usually hidden under gum tissue or it is root surface discolored from age, decay or root canal treatment. Recession can expose root surfaces and crown margins. All-ceramic crowns do not contain metal, however very dark root surfaces (often seen in teeth with root canal treatment) may be a challenge to camouflage. In some instances, a graft of gum tissue can be used to cover the area of recession, restoring the pre-recession appearance.

- **STAINS and COLOUR CHANGES:** All materials can pick up stain. The amount depends on oral hygiene as well as choices of foods (curry tea, tobacco, turmeric, red wine, etc). Dental porcelain typically stains less than natural tooth enamel, and the stain can be removed at dental hygiene appointments. Natural teeth darken with time/age. Therefore, a color match with adjacent natural teeth may become less of a match as your natural teeth age.
- **BLEACHING:** Bleaching is a conservative method of lightening their teeth. There is no way to predict to what extent a tooth will lighten. At times, teeth may be resistant to the bleaching process. Infrequently, side effects may be experienced, such as tooth hypersensitivity and soft tissue irritation.
- **TOOTH DECAY:** Tooth decay may occur on areas of the tooth covered by a crown. If the cement seal at the edge of the crown is lost, decay may form at the junction of the tooth and crown. If the decay is discovered at an early stage, it may be treated with a filling. It is commonly best treated by remaking the crown or fixed bridge.
- **LOOSE CROWN:** A dental crown or fixed bridge may separate from the tooth if the cement is lost or the tooth fractures. Loose restorations accelerate the decay process. Some loose crowns or tooth fractures will require a new crown or fixed bridge, others will not be treatable, requiring extraction.
- **FOOD IMPACTION:** As with natural teeth**,** food may become lodged between dental crowns and under fixed bridges. Dental crowns and fixed bridges are often connected (splinted together), creating the need for specialized hygiene techniques. Gum recession may make food impaction unavoidable, even with the most ideal contour of dental crowns and fixed bridges.
- **EXCESSIVE WEAR:** Sometimes crowns and fixed bridges are used to restore badly worn teeth. If the natural teeth were worn from clenching and grinding the teeth (bruxism), the new crowns and fixed bridges may be subjected to the same wear or even fracture. In general, dental porcelain and metal alloys wear at a slower rate than tooth enamel. At times acrylic guards may be used to reduce the damage caused by bruxism these may also called a splint or night guard.
- **TEMPOROMANDIBULAR DYSFUNCTION (TMJ):** Placement of dental crowns and fixed bridges inevitably result in changes to the occlusion (bite). On rare occasions, the change may precipitate TMD symptoms, even if it technically improves the occlusion.

REMOVABLE PROSTHETICS

Removable prosthodontics is the replacement of missing teeth with dentures that can be removed from the mouth. There are several types of removable dentures.

(1) Complete dentures supported by gum tissue “classic dentures”
(2) Partial dentures supported by teeth and by gum tissue
(3) Over-dentures supported and/or retained by natural teeth or implants.

POTENTIAL PROBLEMS WITH REMOVABLE PROSTHODONTICS

- **CHEWING, STABILITY AND RETENTION:** Removable dentures under the best of circumstances do not have the same chewing efficiency as natural teeth. The ability to chew food depends on the *stability* and the *retention* of the dentures. Stability and retention are affected by many factors, including patient anatomy (gum and bone), supporting teeth or implants, gum tissue, saliva volume and quality, patient dexterity (skill) and fit of the dentures to the gum.
- **APPEARANCE:** Skillfully constructed dentures will support the lips and facial contours similar to when a patient had natural teeth. Dentures can be highly esthetic restorations.
- **SPEECH:** Dentures cover areas of the jaw and palate that are not normally covered. The presence of acrylic and metal in these areas requires significant adaptation of the tongue and lips for proper speech, which may require an adjustment period of many weeks.
- **DENTURE “CLICK”:** Denture click occurs when the upper and lower denture teeth inadvertently contact during speech or mastication. At times appearance goals and functional goals must reach a compromise to eliminate a denture click.
- **TASTE:** Taste buds are located on the tongue, which is not covered by removable dentures. However, the acrylic resin and metal of removable dentures may affect the taste of food, especially if the dentures are not adequately cleaned.

- **STAIN AND CLEANING:** The amount of stain on dentures generally depends on oral hygiene as well as the consumption of such items that stain such as tobacco, red wine, coffee and tea turmeric and curry. Bleach should not be used to clean removable dentures as bleach can corrode the metal portions of the dentures (if present) and severely fade the pink acrylic resin.
- **DENTURE ODOR:** The pink acrylic portion of the denture is a plastic material with inherent porosity that may collect debris and odor. Also dental plaque with its associated odor may accumulate on dentures in the same manner as it accumulates on natural teeth. It is therefore imperative to thoroughly clean your dentures and soak them regularly for the health of your gum tissue (rest) as well as the elimination of denture odor.
- **CHIPPING AND WEAR:** Porcelain teeth wear very little, chip easily if dropped and stain at the junction with the acrylic, Acrylic teeth have more resistance to chipping, but have a tendency to wear down faster than porcelain. If wear adversely affects the appearance or mechanics of bite occlusion, the acrylic resin teeth can be replaced. Chips and cracks of the pink acrylic resin portion can usually be repaired without remaking the denture. Tooth wear varies highly with bite force, choice of foods and parafunctional habits (clenching and grinding).
- **RELINES:** The shape and size of the gum tissue as well as the bone underneath it changes with time. A reline procedure re-adapts the pink acrylic resin portion of the denture to the new shape and size of the gum tissue. Typically, a reline is necessary every three to five years. However, this will vary depending on many individual factors.
- **NUMB LIP (PARASTHESIA):** The nerve to the lower lip traverses through the lower jaw bone. If the bone covering the nerve is lost though extensive bone atrophy over many years, the nerve will lie directly under the gum tissue. Pressure from a removable denture on this area may cause a numb lip in a manner like pressure on your elbow causing numb fingers. This problem requires selective adjustment of the denture base to reduce or eliminate completely the contact in that area. Implants can make this adjustment more predictable. In very rare and extreme situations, the nerve may require surgical repositioning.
- **FOOD IMPACTION:** Removable dentures always have some space between the pink acrylic resin portion and the gum tissue. In addition, there is always some movement of the removable denture during chewing, as gum compresses under load. These factors create a situation where food may accumulate between the denture and the gum tissue. Therefore, it is essential to remove the denture for cleaning after meals to clean them. Removable partial dentures with metallic clasps may have additional food retention problems.
- **DRY MOUTH:** Significant concern is raised with dry mouth and denture comfort, retention and stability. The quantity of saliva may be adversely affected by some systemic problems, medications and/or radiation therapy around the head and neck. Lack of saliva may increase the irritation of a removable denture against the gum tissue, and lack of saliva can severely increase the incidence of tooth decay and fungal infections.

IMPLANTS

Implants are essentially prosthetic tooth roots. They may be used to stabilize dentures, or to support crowns and bridges. Though man-made and thus imperfect, implants are considered highly predictable (95 %+) treatments. Implant longevity depends on many factors including patient health and medications (notably bone preserving and osteoporosis/osteopenia medications, steroids, diabetes, the use of tobacco, alcohol, drugs, oral hygiene, the amount of quality bone, surgical compromises, the degree of biting force and many more.

IMPLANTS FOR FIXED PROSTHETICS

After implant surgery, it is important to keep the area clean but not to disturb the implant. Implants must remain immobilized to heal, if you notice movement, call your dentist. To help prevent this, you should temporarily adhere to a soft diet and avoid pressure to the tissues. If you wear a temporary denture it must be modified before it can be worn. All gum tissue heals better without being covered by a denture. Leaving it out as much as possible will help healing of the gum tissues. You can expect discomfort and minor swelling during the initial healing following surgery. The estimated time between surgical implant placement and restoration is three months in most cases. You may require soft linings placed in your denture during healing and prior to fabrication of your new denture. Be sure to advise your dentist of any sores or ulcers, or any changes in the gum tissues around the implants after the surgery.

IMPLANTS FOR REMOVABLE PROSTHETICS

After implant placement surgery, it is possible that the gum tissue that has been stitched together at the time of the surgery may fail to heal immediately and the line of repair may open slightly. To help prevent this, you should temporarily adhere to a soft diet and avoid pressure to the tissues by leaving your denture out until initial healing is well advanced (usually 7 – 14 days). At that time your denture may be modified before resuming its wear. The denture must not be used after surgery until your dentist has modified it. This modification will occur after each phase of implant surgery. You can expect some discomfort during the initial healing following surgery. The estimated time between surgical implant placement and restoration is three months in the lower jaw and three to six months in the upper jaw. You may need to have frequent soft linings placed in your denture prior to construction of the permanent prosthesis. To promote good healing, you should inform your dentist of any sores or ulcers that persist for 3-4 days or any changes in the gum tissues around the implants after the first surgery.

IMPLANT COMPLICATIONS *includes complications that apply to fixed prosthetics on teeth in addition to the following.*

1. General surgical complications such as pain, swelling, bruising, infection, bleeding.
2. Anatomic risks of surgery typically arise where limited bone volume exists.
   a. In the lower jaw damage to the mandibular nerve (temporary or permanent loss of feeling to the lower lip and chin)
   b. In the upper jaw perforation into the maxillary sinus or nasal cavity.
   c. These risks are reduced with pre-operative imaging (cone beam CT scan) and bone augmentation/ grafting where deficient.
3. Implants may fail to integrate (i.e. may not become firmly anchored in bone). An implant that fails to integrate requires removal and bone grafting may be necessary prior to replacement of the implant.
4. Fracture of implants, abutments or screws are rare, but can happen.
5. The crown or bridge on an implant can be either cemented to an abutment or held in with a screw. Screw retention is preferable when permitted by appearance and optimal implant position. Cemented implant crowns and bridges cannot be predictably retrieved if need should arise. Screw retained implant crowns and bridges have a hole that is often closed with filling material which may affect the appearance or contour of the crown. Screw retained crowns and bridges can be removed if required with little expected difficulty.
6. Following loss, a tooth the gum and bone shrinks/recedes. This loss increases with time and in the presence of infection.
7. Implants do not hold gum and bone like teeth; this can make complete gum fill between implants a challenge at times creating spaces that appear dark. Additionally, the contour of the gum tissue at the neck of the implant may not be identical to the contour before the previous tooth was lost.
8. Eating excessively hard foods can lead to increased soreness under overdentures along with fractured teeth, denture acrylic or damage to implant parts.
9. If the jaw joints or facial muscles are overloaded from excessively hard foods or you clench or grind your teeth, you may experience some jaw joint and facial muscular discomfort.
10. Cleaning the teeth and attachments on implants will be much different from cleaning a conventional denture. Regular cleaning reduces the risk of infections can occur around the implant parts if they are not kept clean. Like other dentures and bridges, the teeth may stain with excessive coffee, red wine, tea or smoking, turmeric and curry.
11. If your denture is removable, the teeth or denture may be damaged if dropped like a conventional denture.
12. The screws attaching the prosthesis to the implants may loosen; they will need to be tightened if this occurs as damage can result to the implant, screw or prosthetic tooth/denture.
13. When denture teeth have worn down, they will need to be replaced. This means that you will be without your denture for up to a few days.
14. Teeth can experience drift and growth throughout life. Implants do not grow so they appear to intrude with time. (may look shorter over time than adjacent teeth). Fortunately this is usually minor, but can be significant in a fraction of the population and may require additional treatment.
15. Contacts found between implants and natural teeth can open with time, (most commonly the front or mesial contact) which may necessitate additional treatment to the tooth, implant or both.

THE ALTERNATIVES TO IMPLANT TREATMENT ARE:

1. No treatment
2. Fixed bridge supported by teeth
3. Removable denture to replace the teeth.

LONG-TERM SUCCESS OF IMPLANT TREATMENT YOU HAVE THE FOLLOWING RESPONSIBILITIES:

1. Follow all instructions regarding soft diet and denture use during the healing after implant surgery
2. Inform us of any adverse experiences
3. Appear for periodic examinations as advised.
4. Use judgment to not abuse or place excessive stresses on the implant, crowns or prosthesis
5. Advise your dentist immediately if any problems are noticed.
6. Clean the implant posts and denture thoroughly as instructed
7. Appear for periodic examinations as advised. There is an additional fee for this service
8. If complications arise allow me the opportunity to help you and be an active participant in maintaining your oral health care

C. TEMPOROMANDIBULAR DYSFUNCTION

Pain or clicking in the region of the jaw joint (*temporomandibular dysfunction or TMJ*) may occur at any time during one's life. Usually multiple factors contribute to this condition. In many instances, jaw muscle spasms are the primary cause of the pain. Sometimes actual joint pathology, such as arthritis, may be present. At times non-dental causes (ear, nose and throat pathology) are significant and should be evaluated by a medical professional, especially if improvement in symptoms is delayed or non-progressive.

In addition to problems with the joints themselves, TMD symptoms may be perpetuated by the habit of clenching or grinding the teeth (*bruxism*). This can occur even with optimum occlusion, normal joints and proper musculature. The emotional state of a person predisposed to this problem has a direct relationship to temporomandibular pain, so that the pain and/or clicking may fluctuate with the emotional state of the individual.

OCCLUSAL DIAGNOSTIC SPLINT THERAPY: Initial treatment with an occlusal and muscle therapy is considered an appropriate conservative and reversible approach. An occlusal diagnostic splint, also known as a bite splint, is used to determine if improvement of the occlusion or a repositioning of the jaw would improve the symptoms. If improvement is achieved with the splint, the occlusal splint may be worn continually, or the occlusion corrected to eliminate the need for the splint. Occlusal splints are usually made of acrylic resin and as such, are subject to breakage and wear; they are intended for relatively short-term use.

Correction of the occlusion may require selective grinding on the chewing surfaces of the natural teeth, crowns or fixed bridges, or may require orthodontic treatment by an orthodontist and/or surgical repositioning of the jaws or teeth by an oral surgeon.

Treatment of the musculature associated with TMD includes exercises, medication, physical therapy, acupuncture, biofeedback, nutritional counseling, ice packs, immobilization, etc. Severe TMD problems may require a coordinated treatment plan with other health professionals.

D. BONE AND TISSUE GRAFTING:

A pre-requisite for implant therapy is adequate supporting bone. If inadequate bone volume exists, additional bone may be generated using your own bone (auto-graft) or donor bone (allo-graft) as an additive or separate procedure. There is a risk of infection, pain, treatment failure, scarring, numbness (transient and permanent) with any surgery and this is no exception. In grafting this risk is increased and you will be prescribed antibiotics. There are specific risks with donor tissue which include remote chance of disease transmission, rejection of the graft. These risks are not present with your own tissue.

PLATELET RICH CONCENTRATES (PRP AND PRF): Platelet rich plasma and fibrin are used in addition other grafting materials with a goal to improve the speed of healing.
Blood is drawn (1-2 small vials taken from your arm on the day of surgery, similar to medical bloodwork) and concentrated in a centrifuge. The components (plasma) are used to hydrate and adhere allograft and (fibrin) as a covering layer on wound sites. Primary risks of platelet concentrates are pain, bleeding and bruising at the site of blood draw.

GINGIVAL AND CONNECTIVE TISSUE GRAFTING: The purpose of gingival grafting is to increase and thicken the attached gum tissue to reduce the likelihood of further gum recession around teeth and implants, to cover exposed root or implant surfaces, to enhance the appearance of teeth and visible gum line, or to prevent or treat root sensitivity or root decay. Sources of the graft are auto-graft (typically taken from the upper jaw, roof of mouth) and allo-graft (donor connective tissue). Primary risks for this procedure are common to all surgeries – pain swelling, bleeding bruising, tingling, numbness, burning sensation, treatment failure, and infection. Specific risks with donor tissue which include, remote chance of disease transmission, rejection of the graft.

SOME INHERENT RISKS AND POTENTIAL PROBLEMS

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as freezing, numbing or Novocaine). In addition, sedative and pain medication can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Sedative or pain medications may cause drowsiness. Therefore, when these medications are being used, you will need to make plans for transportation with another person to and from the office while on these medications.

PROSTHODONTIC TREATMENT DURING PREGNANCY: Elective procedures or procedures that can easily be postponed should generally wait until after childbirth. Treatment of dental pain and urgent procedures can be performed with relative safety to the fetus by minimizing the use of medications. Therefore, it is essential that you inform the dentist of a confirmed or suspected pregnancy.

DENTAL HYGIENE: Teeth, Dentures, Bridges and Implants (All Mouths) should be cleaned at minimum once per day with a brush, low abrasive toothpaste and floss. Your own personal situation may require additional hygiene procedures based on the unique combination of factors that contribute to oral disease. These factors can change with time. Professional hygiene with a licensed hygienist at a frequency tailored to your condition is recommended to reduce the risk of dental disease initiation and progression. Risks of sub-optimal hygiene include decay, recession, pain; odor, gingivitis, periodontal and peri- implant bone loss, tooth mobility and even tooth loss. Additionally, systemic complications are impacted with uncontrolled periodontal inflammation which may contribute to decreased diabetic control, increased risk of stroke and heart disease risk, ED, and low weight pre-term birth.

FOLLOWING DENTAL RECOMMENDATIONS AND INSTRUCTIONS DURING TREATMENT:
Following post-operative instructions, hygiene instructions, re-care recommendations and taking medications as recommended is the responsibility of the patient and is an important aspect of the successful outcome of any treatment.

RESPONSIBILITY TO SEEK AND FOLLOW MAINTENANCE AFTER ACTIVE TREATMENT IS COMPLETE: Another important aspect of maintaining a successful outcome is maintenance and evaluation by the treating dentist or your general dentist. This includes periodontal hygiene, restorative evaluation and treatment and medical treatments with your physicians.

COMPLETE DISCLOSURE OF MEDICAL HISTORY, PRESCRIPTION AND OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS IS REQUIRED.

CHANGES TO YOUR HEALTH AND MEDICATIONS DURING THE COURSE OF TREATMENT CAN IMPACT THE OUTCOME OF TREATMENT. PLEASE KEEP US UPDATED IT IS FOR YOUR BENEFIT.

COMMENT

Provincial law requires that you be given certain information and that we obtain your consent prior to beginning treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your specific treatment(s), the known risks associated with the treatment and the feasible treatment alternatives; that you have been given an opportunity to ask questions and that all your questions have been answered in a satisfactory manner.

INFORMED CONSENT AND AUTHORIZATION

I certify that I have read and understand all eight pages of the *Informed Consent* which outlines 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.

Recognizing the potential problems and risks of restorative/prosthodontic treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials and care, if it is deemed for my best interest. In addition, I consent that photographs and/or record of the procedures may be used for teaching purposes.

Signed: _____ Date: _____

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