Southern Smiles
FAMILY & COSMETIC DENTISTRY
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Release of all Claims Department
Consent for Restorations, Crowns, Bridges & Laminates

Patient:_____ Date:_____
Tooth#_____

It has been explained to me that there are certain inherent and potential risks in any treatment of procedure, (including the administration of any necessary local anesthesia) which include, but are not limited to:

A. Postoperative discomfort and swelling that may persist for several days.
B. Stretching of the mouth with resultant cracking and bruising.
C. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lips, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
D. Sensitivity to filled/crowned teeth that may necessitate root canal therapy.
E. Discoloration of the gum tissue.
F. Swelling, bruising and bleeding of the adjacent gum tissue.
G. Inability to perfectly match natural enamel with porcelain.
H. Inability to eliminate spaces between teeth.

The procedure must be completed (seated) within 60 days of impressions. If impressions must be redone because the procedure has not been completed within the time limit, I will be responsible for additional fees for the remake.

I understand that I am responsible for making sure that I come in immediately if the temporary crown comes off during the period of time. I understand that the teeth can shift in a very short period of time (overnight sometimes) and that if the temporary comes out the permanent crown or crowns may not fit and may need to be remade by the dental lab in which I would be responsible for partial or full cost of the replacement crown.

I understand that a permanent crown is sometimes seated with temporary cement so that the patient can see if the fit is comfortable and pain free. I understand that I am responsible for keeping my appointment for the permanent cementation and that if I do not keep this appointment that I am responsible for the cost of tooth repair at a later time.

In addition, I understand that I have the option of receiving a metal or porcelain crown in most cases and am financially responsible for any porcelain fracture. It has been explained to me that biting on extremely hard foods or non-food can cause porcelain fracture.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction due to the individual despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I certify that I have had an opportunity to read and fully understand the terms and words within the above and consent to the procedure(s)

Patient/Guardian Signature _____ Date_____