DOVE DENTAL
SPECIALISTS

Filling Consent Form

WORK TO BE DONE: I understand that I am having the following work done: _____

1. **DRUGS AND MEDICATIONS:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction)
2. **RISKS OF DENTAL ANESTHESIA**: I understand that pain, bruising and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with local anesthetics. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being **Root Canal Therapy** following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
   I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care and understand that the fee proposed is subject to change, depending upon those unforeseen or undiagnosed conditions that may only become apparent once treatment has begun
4. **RISKS OF FILLING PROCEDURE:** I understand that care must be exercised in chewing after the placement of a filling. I understand that a more extensive filling than originally diagnosed may be required due to additional decay present at the time of treatment. Following a filling, there may be sensitivity of the teeth that can last for a short period of time. If the sensitivity continues, I will notify my dentist as this can be a sign of more serious problems.

I understand that delaying treatment may cause harm, the dental disease may progress, further damage to teeth may occur and swelling and infection may occur creating additional treatment and associated expenses.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I

have had full opportunity to discuss and ask questions regarding the dental treatment and all questions have been answered to my satisfaction.

Consent for Fillings

Dear Patient,

We want to inform you of our policy regarding filling material and associated costs. We only do Composite fillings (white/tooth colored). We do not provide Amalgam (silver fillings). The advantages for composite fillings include but are not limited to:

1. Better esthetics
2. No Mercury
3. Less removal of natural tooth structure

While Insurance Companies are aware of the benefits some still pay for Amalgam only. In that case, it is the patient's responsibility to pay the difference between Amalgam and Composite. If you wish to have a silver filling, your alternative option is to change to a provider who uses this material. This document confirms you understand your treatment options. If you have any questions, please do not hesitate to ask the Doctor or the front Desk Staff.

Name: _____

Email: _____ Phone: _____

_____ _____

SignatureóPatientκtl·ℕŜyΰκDdzl·ℕŘλl·yϫκwŜLJℕŜăŜyΰl·ΰλØŜύ Date

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