I UNDERSTAND that dental treatment requiring COMPOSITE FILLING procedures, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) Often after preparation of teeth for the placement of any restoration, the teeth may exhibit sensitivity, which can range from mild to severe. This sensitivity may last only for a short period of time or may last for much longer periods. If sensitivity is persistent, the doctor should be notified immediately such that all possible causes of the sensitivity may be diagnosed and treated.

_____(initials) It's common after placement, or replacement of any restoration, small fracture lines in tooth structure are created. Most of the time these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling, and placement or replacement, but may manifest at a later time in the form of thermal or bite sensitivity.

_____(initials) When fillings are placed or replaced, the preparation of the teeth for fillings often requires the removal of tooth structure adequate to insure the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, tooth preparation(s) may lead to exposure or trauma to underlying pulp tissue. Should the pulp not heal, which often times is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

_____(initials) There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances could be permanent.

_____(initials) Effort will be made to match your natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, smoking, etc. may cause the shade to change. The dentist has no control over these factors.

_____(initials) Due to extreme chewing pressures or other traumatic forces, it is possible for composite fillings to be dislodged or fractured. The resin-enamel bond may fail, resulting in leakage and recurrent decay around the composite filling. The dentist has no control over these factors.

_____(initials) Composite resin technology continues to advance, and some materials, and some fillings may have to be replaced by better, improved materials. Having silver amalgam fillings replaced with composite filings has not been proven scientifically to improve, alleviate, or prevent any current or future health condition.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

Remainder of This Page Left Blank Intentionally
Signature Page to Follow

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warrantees have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

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