Informed Consent for Tooth Fillings

File No	:	39359			
Patient Name	:	DENZIL MANUEL DSOUZA	**Date**	:	10-11-2023
Nationality	:	Indian	**Gender**	:	Male
Emirates ID No.	:	784-1986-0518576-2	**DOB**	:	07-12-1986

I UNDERSTAND that the treatment of my dentition involving the placement of composite resin fillings which may be more aesthetic in appearance than some of the conventional materials [which have been traditionally used to fill front and back teeth], such as silver amalgam or gold, may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this treatment.

BENEFITS:
Eliminate decay, relieve pain, fill in a hole or space in a tooth, cover eroded area, and protect a sensitive surface

CONSEQUENCES OF NOT HAVING WORK DONE or POSTPONING :
May loose the tooth, tooth may fracture, decay will get worse, may result in need for a root canal

ALTERNATIVES:
Temporary filling

POSSIBLE COMPLICATIONS:
Tooth may abscess from the filing, may fracture the tooth, tooth can be sensitive to temperature change, or filling may fall out.

Necessity for Root Canal Therapy:
When any type of fillings are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure adequate to insure sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue.
Should the pulp not heal, which oftentimes is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

Injury to the Nerves:
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 could occur is usually temporary, but in rare instances could be permanent.

Aesthetics or Appearance:
Effort will be made to closely approximate the 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 exhibit a change in shade. The dentist has no control over these factors. Tooth lightening may also result in fillings in front teeth becoming relatively darker.

Breakage, dislodgment or bond failure:
Due to extreme chewing pressures or other traumatic forces, it is possible for composite resin fillings or esthetic restorations bonded with composite resins to be dislodged or fractured. The resin enamel bond may fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

Patient's Initials:

I understand that ALL medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of dentistry, provided my identity is not revealed

It is the patient's responsibility to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions, including the scheduling and attending all appointments. In the event I wish to discontinue the treatment, I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall health may be affected by my decision.
I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in My overall health stemming from this condition.
I have had the chance to ask questions and express concerns about my dental condition, the treatment options, and my refusal of treatment. The undersigned provider has answered all my questions and addressed all my concerns. I understand the full scope of the situation and am making an informed decision.

Informed Consent:

The fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Abdulrahman and / or his associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as Described above.

☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

Sign here, only if all of your questions have been answered to your satisfaction

DENZIL MANUEL DSOUZA — 10-11-2023

Patient's name | **Signature of Patient Legally authorized Representative** | **Date**

Dental Treatment Consent Form

Patient details					
Patient Name	:	DENZIL MANUEL DSOUZA	**Reg #**	:	39359
Gender	:	Male	**Nationality**	:	Indian
DOB/Age	:	07-Dec-1986	**Mobile #**	:	0585871286
Email	:	hr.fc@central-hotels.com	**Facebook A/c**	:	

****Please read and sign at the bottom of form.

1. **X-RAYS**

2. DRUGS AND MEDCATIONS - I understand that antibiotics and analgesics and other medications can cause allergic reactions, causes redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN - I understand that during treatment it may be necessary to change or add procedure because of condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedure. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. REMOVAL OF TEETH - Alternative to removal has been explained to me (Root canal therapy, crowns, periodontal surgery, etc.) and I authorize the dentist to remove the following teeth. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months) or fractured jaw.

5. CROWNS, BRIDGES AND CAPS - I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily that I must be careful to insure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) before cementation.

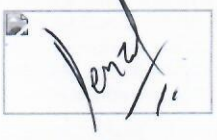
6. ENDODONTIC TREATMENT (ROOT CANAL) - I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

7. FILLINGS - I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

8. DENTURES, COMPLETE OR PARTIAL - I understand the wearing dentures are difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I stand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. I realize that full or partial dentures are artificial, constructed of plastic, metal, and /or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage.

9. IMPLANT - I understand thatthe surgical placing of implant is possible and has high success rate, but has no guarantee of success can be assured for this kind of treatment; About classical treatment by way of fixed prosthesis or affixed prosthesis (removable) suitable to my case; Of the necessity of bi-yearly clinical and radiographical controls during the three years that follow the placing of implants, and yearly ones afterward; That incase of failure, the implant will be removed at no further cost.

I, the undersigned, certify that I am rightfully informed by my dentist about my x-rays, drugs and medications, the dental treatment plan and that I am medically fit to do the treatment, the dental procedures, the price, the complications it may arise.I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.



Date: 10-Nov-2023

Signature of Patient

Signature of Parent/Guardian if patient is minor

Date: 10-Nov-2023

For clinic information, how did you come to know our clinic? Please mention the name.

Magazine **School:** **Establishment:**

Insurance Company **Your Staff/Friend/Relative:**