INFORMATION & INFORMED CONSENT · RESTORATIVE DENTISTRY

CD-C10

Porcelain Crowns

Please read this form carefully before your treatment. It explains what is involved, the benefits, the risks and your options. Ask your dentist about anything you do not understand. You do not have to sign until you are ready.

PATIENT DETAILS

PATIENT NAME

DATE OF BIRTH

TOOTH / TEETH

CROWN MATERIAL AND SHADE

TREATING DENTIST

CLINIC

01 About the treatment

A crown is a cap that covers a weakened, cracked, heavily filled or root-treated tooth to restore its shape and strength. The tooth is reduced on all sides, an impression or digital scan is taken, and a temporary crown is placed. The final porcelain or zirconia crown is cemented at a second visit.

EXPECTED BENEFITS

- Protects a weak tooth from fracture
- Restores shape, function and appearance
- Long-lasting, typically 10 to 15 years or more

ALTERNATIVES

- No treatment (with increased risk of fracture)
- Large filling or onlay
- Extraction and replacement with an implant, bridge or denture

02 Risks and possible complications

All dental treatment carries some risk. Most complications are uncommon and manageable, but you should know about them before deciding. Risks specific to you, including those relating to your medical history, have been discussed with you.

- **Local anaesthetic.** Numbness usually wears off within 2 to 5 hours. Bruising or tenderness at the injection site, temporary jaw stiffness or a racing heartbeat can occur. Rarely, an injection touches a nerve and causes numbness or tingling that lasts weeks or longer, or an allergic reaction occurs.
- **Sensitivity** to hot, cold or biting for days to weeks after preparation. It usually settles.
- **Nerve damage.** Preparing a tooth can inflame the nerve. Some teeth (more often heavily filled or cracked teeth) later need root canal treatment, sometimes through the new crown.
- **Fracture or chipping** of the porcelain, especially with grinding or chewing very hard foods.
- **Loosening** of the restoration, or decay developing at the margin if plaque is not removed.
- **Gum recession** may expose the margin of the restoration over time.
- **Colour** cannot be altered once the restoration is cemented.
- **Irreversible.** Tooth structure removed during preparation cannot be replaced.

03 Your acknowledgement

Tick each box to confirm you understand and agree.

- [ ] I have read this form, or it has been read to me, and I understand it.
- [ ] The dentist has explained the proposed treatment, why it is recommended, the expected benefits, the material risks and the reasonable alternatives, including no treatment.
- [ ] I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- [ ] I understand that dentistry is not an exact science and that no guarantee has been given about the outcome or how long treatment will last.
- [ ] I have given the dentist a complete and accurate medical history, including medicines, supplements, allergies and pregnancy (if applicable), and I will tell the clinic of any changes.
- [ ] I understand that unforeseen findings during treatment may require a change in plan, and that the dentist will discuss this with me where practical.
- [ ] I have received a written estimate of fees. I understand that fees may change if the treatment plan changes, and that health fund rebates are my responsibility to confirm.
- [ ] I consent to clinical photographs, X-rays and scans being taken and kept in my record. These will not be used for any other purpose without my separate written consent.
- [ ] I understand that I may withdraw my consent at any time before or during treatment.

04 Financial consent

ESTIMATED FEE ($) _____ ITEM NUMBERS / QUOTE REFERENCE _____

05 Consent

I, the undersigned, consent to **Porcelain Crowns** as described above, and to the administration of any local anaesthetic or other medicines needed for this treatment.

Patient (or parent / guardian / substitute decision-maker)

FULL NAME _____ SIGNATURE _____ DATE _____

Dentist

I have explained the treatment, risks, benefits and alternatives, and answered the patient's questions.

NAME _____ SIGNATURE _____ DATE _____

Interpreter (if used)

NAME / LANGUAGE _____ SIGNATURE _____ DATE _____