

# 21 DENTAL GROUP

## Discussion and Informed Consent for Inlay(s)/Onlay(s)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment and Tooth Number(s): \_\_\_\_\_

**I understand that by signing below I am authorizing the procedure(s) to be performed and I have read and understand the entirety of this form, including the possible risks and complications of the chosen procedure(s) and the available alternatives.**

### Indirect (laboratory made):

#### *Patient's initials required*

Inlays are typically used for a large restoration that fills the space between the cusps, high points, or rounded edges, at the center of the tooth's surface or biting surface.

Onlays are a larger restoration that typically includes one or more cusps of the tooth, which are high points, or provides full coverage of the biting surface. An onlay is very similar to a three-quarter crown.

### Important Information:

\_\_\_\_\_ Restoration of a tooth with a inlay/onlay may require two phases: 1) preparation of the tooth, making an impression or mold (which is used for fabrication of the final restoration), sending that mold to a dental lab, then construction and temporary cementation of a temporary (interim) inlay/onlay or in some cases the use of CAD-CAM (computer-aided scanning of the dental arch and teeth). This option may not require a temporary placement and 2) removal of the temporary (interim) inlay/onlay, (if required) adjustment and cementation of the permanent restoration after aesthetics and function have been verified and accepted.

\_\_\_\_\_ Once a temporary (interim) restoration has been placed, it is essential to return to have the permanent restoration placed as the temporary restoration does not function as well as the permanent inlay/onlay. If the temporary breaks or comes loose or if the tooth is uncomfortable, this should be reported to the dentist immediately. Failing to replace the temporary (interim) restoration with the permanent restoration could lead to decay, gum disease, infections, problems with my bite and loss of the tooth/teeth. In the event CAD-CAM inlays /onlays are fabricated, a temporary restoration may not be utilized.

### Benefits of Inlay(s)/Onlay(s) Not Limited to the Following:

\_\_\_\_\_ I understand that a reasonable aesthetic appearance may be achieved.

\_\_\_\_\_ Establishes an occlusal or "chewing" surface with opposing teeth.

\_\_\_\_\_ An inlay/onlay is typically used to strengthen and restore a tooth damaged by decay, fracture or previous fillings (restorations). It can also serve to improve tooth contours and the way your teeth fit together.

### Risks of Inlay(s)/Onlay(s) Not Limited to the Following:

\_\_\_\_\_ I understand that preparing a tooth for an inlay/onlay may further irritate the nerve tissue (called the pulp) in the center of the tooth, leaving my tooth feeling sensitive to heat, cold or pressure. Such sensitive teeth may require additional treatment including endodontic or root canal treatment.

\_\_\_\_\_ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

\_\_\_\_\_ I understand that an inlay/onlay may alter the way my teeth fit together and make my jaw joint feel sore. This may require adjusting my bite by altering the biting surface of the restoration, adjacent teeth or opposing teeth.

\_\_\_\_\_ I understand there is a risk of aspirating (inhaling) or swallowing the inlay/onlay during treatment.

**Local Anesthesia:**

\_\_\_\_\_ In connection with my dental work, the use of local anesthetic may be used for pain control during dental procedures. All anesthetics create risks and possible side effects. These include, but are not limited to swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction and altered sensation that may lead to biting the lip or tongue. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and occasionally may be permanent.

\_\_\_\_\_ I understand that in addition to the risks and complications associated with implants and prosthetics, certain complications may result from the use of anesthetics (numbing agent) or sedatives. The risks, benefits and alternatives regarding anesthesia have been explained to me and I will disclose any allergies I have and/or any substances or medications I am taking because they may affect my response to the anesthetic or sedative.

**Patient Criteria**

\_\_\_\_\_ In connection with my dental work, the use of local anesthetic may be used for pain control during dental procedures. All anesthetics create risks and possible side effects. These include, but are not limited to swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction and altered sensation that may lead to biting the lip or tongue. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and occasionally may be permanent.

**Check the boxes below that apply to you:**

**Consent**

- I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.
- I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.
- I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.
- I consent to have the above-mentioned treatment.
- While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

**or**

**Refusal**

- I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

\_\_\_\_\_ Patient or Patient's Representative

\_\_\_\_\_ Date

\_\_\_\_\_ Witness Signature

\_\_\_\_\_ Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

\_\_\_\_\_ Dentist Signature

\_\_\_\_\_ Date