

**LONDON DENTAL GROUP**  
Dr. Mark Lima & Dr. Jennifer Sogan  
**116 E. High St. London, OH 43140**  
**(740)852-5771**

**RESTORATIONS, CROWNS, BRIDGES, and/or LAMINATES CONSENT FOR TREATMENT**

**Patient Name:** \_\_\_\_\_ **Chart #** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Tooth Number(s)** \_\_\_\_\_

I voluntarily request Dr. \_\_\_\_\_, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as; \_\_\_\_\_

It has been explained to me that there are certain inherent and potential risks in any treatment or procedure, (including the administration of any necessary local anesthesia, which include, but are not limited to:

- A. Postoperative discomfort and swelling that may persist for several days.
- B. Stretching of the corners of the mouth may result in cracking and bruising.
- C. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lips, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
- D. Sensitivity to filled/crowned teeth that may necessitate root canal therapy or extraction.
- E. Discoloration of the gum tissue.
- F. Swelling, bruising and bleeding of the adjacent gum tissue.
- G. Inability to perfectly match natural enamel with porcelain.
- H. Inability to eliminate spaces between teeth.

The procedure **MUST** be completed (seated) within 45 days of impression. If impressions must be redone because the procedures have not been completed within the time limit, I will be responsible for all additional fees for the remake.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exist a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful and that a worsening of my condition would occur sooner without the recommended treatment.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the procedures and hereby consent to treat.

**Patient Signature** \_\_\_\_\_ **Print Name** \_\_\_\_\_

**Doctor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

---