SKHDENTISTRY
519-745-1821

CONSENT FOR ESTHETIC RESTORATIVE WITH NO DECAY

I understand that this is an elective treatment and that I am comfortable with the risks associated with it. I understand that during the procedure, we may find that additional treatment is necessary which may not have been known to me before the procedure began. I have chosen veneers and bonding, or crowns, over the alternatives that have been explained to me.

I have been informed that complications might include, but are not limited to:

1. I may have temporaries on my teeth until such time the veneers are delivered, which may break and be dislodged and require replacement at my expense
2. Some of my opposing teeth may need to be altered and my bite may need to be altered
3. Some of my teeth may become sensitive and root canals may be required
4. Should teeth fracture during preparation, crowns may be required
5. There may be chipping, fracture, and discoloration as time progresses, which might not be reparable. Replacement, at my expense, may be required
6. There is no guarantee as to how long the veneers and bonding will last, and I have been instructed in hygiene and controlling parafunctional habits (wearing a night guard)
7. Once I have approved of the shade (color) of the veneers and they are delivered, if I wish a change, it will be at my expense (There will be a try-in appointment where changes can be made).
9. Other foreseeable risks not stated above include:_____

In addition, the consequences of non-treatment have been explained to me. I have also been given instructions in care and maintenance regarding this procedure and agree to follow the instructions carefully, including wearing a night guard.

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment. I have discussed my treatment with my dentist and have been given an opportunity to ask questions and have them fully answered.

Patient Signature:_____ Date:_____

Witness Signature:_____