

I, _____, understand that cosmetic treatment which I have requested is: ____ Not clinical necessary. This treatment is 100% cosmetic driven. ____ Clinically necessary and has a cosmetic component to it.

I understand that cosmetic dental procedures to be performed may entail certain risks and possible unsuccessful result, with even the possibility of failure to achieve the results which I may desired or expect. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following:

1. Local Anesthesia: Our office delivers local anesthetic in the form of nerve block and/or local infiltration using lidocaine, mepivacaine, articaine, and/or marcaine. Side effects and/or complications associated with local anesthetic include but are not limited to rapid heartbeat; fainting; hyperventilation; allergic reaction; overdose; temporary or permanent paresthesia (face feeling numb); pain; bruising; swelling; shocking to the nerve; and or jaw muscle tenderness. _____

2. Reduction or roughening of natural tooth structure: In making preparation of teeth for the reception of cosmetic veneers, it may be necessary to reduce or roughen the surface of the tooth to which the veneer(s) may be bonded. This preparation will be done as conservatively as possible. If the veneer covering breaks or comes off, the uncovered tooth may become sensitive and more decay susceptible. _____

3. Sensitivity of teeth: During different stages of treatment, some sensitivity is normal. Even though expected sensitivity is usually mild and temporary, sensitivity may linger or become permanent.

Additional treatment with additional fees may be needed to treat sensitivity. Should sensitivity occur and persist for any length of time, please contact the office for instructions. _____

4. Chipping, breaking or loosening of bonding, crowns or veneers:

Despite all precautions taken in fabrication and placement of restorations, this could occur. Many factors may contribute to this including but not limited to: chewing hard foods; changes in occlusal (biting) forces; daytime or nighttime grinding and clenching; traumatic blows to the mouth; breakdown of the bonding agents; cavity development around or under restorations, and other conditions over which the doctor has no control. _____

5. Irritation, discoloration, Sensitive or allergic reactions of gums to materials used and or treatment: Temporary sensitivity, irritation, and discoloration of the gums is normal and expected. Long term or permanent occurrence is rare but possible. Should this occur, please contact this office for instructions. _____

6. Esthetic/Appearance: Every effort will be made to match and coordinate both the shape and color of veneers, bonding and crowns which will be placed in order to be cosmetically pleasing to the patient. However, differences between the natural dentition and artificial materials available may make it impossible to have a perfect match to your natural dentition. _____

7. Longevity: It is impossible to place any specific time criteria on the length of time that veneers, crowns and bonding should last. These time periods vary from a patient's individual habits or circumstances, which may be either internal, external or both. It is the patient's responsibility to immediately inform the doctor and seek attention from him/her should any undue or unexpected changes on restoration occur. To maximize longevity of restorations, all instructions must be diligently followed, including attending all recommended appointments.



El Paso
Quality Dentistry

COSMETIC TREATMENT BONDING, CROWNS, AND VENEERS

I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for these services have been explained to me and are satisfactory.

By signing this form, I am freely giving me consent to allow and authorize Dr. _____ to render any treatment deemed necessary, desirable, and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications

Patients Name
(please print)

Doctors Name
(please print)

Date

Signature of
Patient, or
Guardian

Witness Name
(please print)

