OPEN & AFFORDABLE DENTAL BRACES

Consent for Esthetic Veneers/Crowns

Patient's Name: _____

This form and your discussion with your doctor are intended to help you make an informed decision about your procedure. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. In order to increase the chance of achieving optimal results, you have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable). Your doctor is available to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

I have been informed of and understand the potential risks related to this procedure include but are not limited to:

_____ Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials.

_____ Discomfort, increased spacing between teeth, altered bite, altered speech, change in esthetic appearance of teeth and/or smile.

_____ The need for future treatment, as this procedure may not prevent future tooth decay, tooth fracture, infection or gum disease.

_____ Nerve injury, which may occur from the procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment.

_____ Possible breakage/dislodgement/bond failure of material, reduction in tooth structure.

_____ Root resorption with subsequent loss of tooth/teeth, partial bleaching effect, requiring additional procedures.

_____ After final cementation, no/minimal changes to the esthetics, color or shape of teeth can be made and in the result that post procedure satisfaction changes, a refund will not be available.

I have been given time to evaluate the esthetics of my teeth and I understand these risks, and my signature signifies I am giving final esthetic approval to my provider before delivery, no other changes can or will be made after cementation.

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____