MedPro Group
a Berkshire Hathaway company

Patient Name: _____

Date of Birth: _____

Informed Consent for Cosmetic Dentistry

I. Recommended Treatment

I hereby give consent to Dr. _____ to perform Cosmetic Dentistry procedure(s) on me or my dependent as follows: _____ _____ ("Recommended Treatment") and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: _____ _____ but I wish to proceed with the Recommended Treatment described above.

III. Risks and Complications

I understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These potential risks and complications, include, but are not limited to, the following:

1. Drug reactions and side effects.
2. Damage to adjacent teeth or tooth restorations.
3. Sensitivity of teeth.
4. Chipping, breaking or loosening of the veneer.
5. Injury to soft tissues adjacent to veneer due to bonding or bleaching agents.
6. Necessity for a more extensive restoration, such as a crown, than originally diagnosed.
7. Inability to exactly match tooth coloration.

8. Changes in the shade, aesthetics, and appearance of the restoration, which may occur over time.

9. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.

10. Changes in speech (which are usually temporary).

11. Changes to the bite or position of the temporomandibular joint which may require further treatment or adjustment.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____