

# Informed consent for cosmetic treatment

**(including bleaching, whitening, bonding and veneer)**

I, \_\_\_\_\_, understand that treatment of my dentition for which I desire cosmetic dental procedures to be performed may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results that may be desired or expected. Even though care and diligence is exercised in the treatment, there are neither guarantees of anticipated or desired results nor any assurance of the longevity of the treatment. I agree to assume those risks, possible unsuccessful results and/or failure associated with but not limited to the following:

**1. Reduction or roughening of tooth structure**

In preparing the teeth for the reception of cosmetic veneers, it may be necessary to slightly 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 more susceptible to decay.

**2. Sensitivity of teeth**

Even though in the majority of the cases (whitening, bleaching, bonding and veneering teeth) there is usually no appreciable sensitivity, this type of treatment may cause teeth to become sensitive. Should sensitivity occur and persist for any length of time, please contact this office for an examination.

**3. Chipping, breaking or loosening of the veneer**

No matter how well the veneer is placed, this could occur. Many factors may contribute to this happening, including chewing of excessively hard materials, changes in occlusal (biting) forces, traumatic blows to the mouth, breakdown of the bonding agents and other conditions over which the doctor has no control.

**4. Sensitive or allergic reactions of soft tissues to whitening, bleaching or bonding agents**

This is an unusual occurrence. The gums or soft tissues of the mouth, which may be exposed to the various agents used in these procedures, may exhibit an allergic response. Also, gum tissues may in some cases exhibit signs of inflammation. Should this occur, please contact this office to be examined.

**5. Aesthetics/appearance**

Every effort possible will be made to match and coordinate both the form and shade of veneers and/or bonding agents to be cosmetically pleasing to the patient. However, there are some differences that may exist between the natural dentition and the artificial materials of the veneers and bonding agents, making it impossible to have the exact shade and/or form to perfectly match your natural dentition.

**6. Longevity**

It is impossible to identify any specific criteria on the length of time that veneers and bonding should last or for the lightened appearance of whitened or bleached teeth to maintain the lightened shades. These time periods may vary depending on many conditions existing from patient to patient as well as each patient's individual habits or circumstances.

It is the patient's responsibility to inform the doctor and seek attention from him/her should any undue or unexpected problems occur or if the patient is dissatisfied. Also, all instructions must be diligently followed, including scheduling and attending all appointments.

**Informed consent**

I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received all 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 or 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 my consent to allow and authorize Dr. \_\_\_\_\_ and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications.

Tooth No(s). \_\_\_\_\_

\_\_\_\_\_  
*Patient signature/legally authorized representative* Date \_\_\_\_\_

\_\_\_\_\_  
*Printed name if signed on behalf of the patient* Relationship \_\_\_\_\_

\_\_\_\_\_  
*Witness signature* Date \_\_\_\_\_