Bright Smiles Dentistry

CONSENT FOR RESTORATIONS, CROWN, BRIDGES, AND/OR LAMINATES

Patient name:_____ Account #:_____ Tooth #:_____Date:_____

I voluntarily request Dr. _____, and such associates, technical assistants, and other health care providers as they may deem necessary to treat my condition which has been explained to me as;_____

It has been explained to me that there are certain inherent and potential risks in any treatment or procedure, (including the administration of any necessary local anesthesia) which include but are not limited to:

- Postoperative discomfort and swelling that may persist for several days.
- Stretching of the corners of the mouth may result in cracking and bruising.
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the lips, chin,gums,cheek,teeth and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
- Sensitivity to filled/ crowned teeth that may necessitate root canal therapy or extraction.
- Discoloration of the gum tissue.
- Swelling, bruising and bleeding of the adjacent gum tissue.
- Inability to perfectly match natural enamel with porcelain.
- Inability to eliminate spaces between teeth.

The procedure must be completed within 45 days of impression. If impressions must be redone because the procedures have not been completed within the time limit, I will be responsible for additional fees for the remake.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

Fees: Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or applicable coverage.

Consent: I have had the opportunity to ask questions about the treatment, alternatives, risks, outcomes, and costs and have had my questions answered before I signed.

I have read, understand and consent to the above treatment, subject to changes in treatment plan.

Patient name:_____Patient/Guardian signature:_____Date:_____

Doctor Signature:_____ Date:_____