CONSENT Bonding Treatment for Anterior

Cosmetic Treatment for Anterior (front teeth) Dental Bonding

I,

Patient's First Name *

Patient's Last Name *

understand that the 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, which may be desired or expected. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in this subject treatment, there are no guarantees or desired results nor the longevity of the treatment).

1. **Reduction or roughening of tooth structure:** In making preparation of teeth for the reception of cosmetic bonding, it may be necessary to slightly reduce or roughen the surface of the tooth the bonding is being done. This preparation will be done as conservatively as possible. If the bonding 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 bonding:** No matter how well done, this could occur. Many factors may contribute to this happening such as: mastication of excessively hard materials; changes in occlusal (biting) forces; traumatic blows to the mouth; breakdown of the bonding agents; and other such conditions over which the doctor has no control.
4. **Esthetics/Appearance:** Every effort possible will be made to match and coordinate both the form and shade of bonding and/or bonding agents which will be placed in order to be cosmetically pleasing to the patient. However, there are some differences, which may exist between the natural dentition, and the materials, which are artificial, making it impossible to have the shade and/or form perfectly match your natural dentition.
5. **Longevity:** It is impossible to place any specific time criteria on the length of time that bonding would last or for the lightened appearance of whitened or bleached teeth to maintain the lightened shades. These time periods may vary from a very short time to a very long time depending upon many conditions existing from patient to patient, and/or upon each 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 problems occur or if the patient is dissatisfied. Also, all instructions must be diligently followed, including scheduling and attending all appointments.
- In an event the bonding chips or breaks, Dc Pearls Dental Boutique will assume responsibility for the repair of bonding up to 1 time in the first 3 month starting from the day the procedure is completed free of charge. After the 3 months period or 1 time of repair (whichever comes first) the full price for the bonding will be applied.
- All the alternative treatment options including but not limited to: No Treatment, porcelain Veneers, and/or Porcelain Crown (their pros and cons) have been discussed with me prior to the procedure.
- Fabrication of mouth guard or other prosthesis may be necessary and recommended by Dr. Ardekani in order to protect the restoration (bonding).

INFORMED CONSENT TO TREATMENT: 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 potential 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. Ardekani 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

Patient's First Name *

Patient's Last Name *

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Date *

12/10/2021