Sheila Harris, D.D.S.

COSMETIC TREATMENT
INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for elective dental cosmetic treatment. Each item should be checked off after the patient has the opportunity for discussion and questions.

__________ 1. I, THE UNDERSIGNED, CONSENT TO Dr.________________, his/her partners, associates, administrative team, dental assistants and/or staff performing on me the outlined Cosmetic Treatment Plan (***as outlined on the "Treatment Form" that has been provided to me***).

__________ 2. I accept and understand that this cosmetic procedure(s) ***is/are elective in nature and not treatment for any dental disease***.

__________ 3. I accept and understand that although Dr.________________ will make every effort to improve my smile to my desires, there are limitations due to function, color, extent of inherent staining, shape and/or placement of the original teeth.

__________ 4. I accept and understand that cosmetic results are subjective; thus, ***the outcome of my Cosmetic Treatment Plan may not completely meet my expectations***.

__________ 5. I accept and understand that the alternatives to the Cosmetic Treatment Plan, which have been fully discussed with me, include but are not exclusive of:

____________ a. Orthodontic Treatment.

____________ b. No Treatment.

__________ 6. ***Each option has been fully explained to me with its' benefits, risks, pros, cons and approximate investment cost***. I accept and understand that there are ***risks and limitations*** to all procedures. For this cosmetic treatment these risks and limitations include, but are not exclusive of:

___________ a. P*ain in the jaw.*

___________ *b. Chipping of restorations*

___________ *c. Change in speech*

___________ *d. Change in appearance*

___________ *e. Need for elective root canal therapy (**at additional cost**)*

___________ f. *"Show Through" of inherent staining over time*.

___________ g. The cosmetic changes are permanent and, although they can be changed again, they cannot go back to how they were originally.

__________ 7. I have had the opportunity **to discuss** the Cosmetic Treatment Plan, and have had an opportunity **to ask questions**, and am fully satisfied with the answers received.

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__________ 8. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

__________ 9. I accept and understand that, as with any medical or dental procedure, there are no guarantees as to the longevity of the work performed. I also accept and understand that ***the Cosmetic Treatment Plan does not contain any warranty against loss of teeth due to diseas***e.

__________ 10. I accept and understand that I play a major role in the maintenance of my teeth and restorations.

__________ 11. I agree to maintain good oral hygiene and keep regular dental check-ups and cleaning appointments with Dr.________________, at least every 6 months.

__________ 12. I agree to wear my night guard every night as instructed and to follow all instructions given to me.

__________ 13. I accept and understand that, if these conditions are complied with, the ***ONLY*** **WARRANTY** provided under the Cosmetic Treatment Plain is:

____________ **a. YEAR ONE (1)** – replacement at no charge.

____________ **b. YEAR TWO (2)** – patient pays 25% of current fee.

____________ **c. YEAR THREE (3)** – patient pays 50% of current fee.

____________ **d. YEAR FOUR (4)** – patient pays 75% of current fee.

____________ **e. YEAR FIVE (5)** and subsequent years – patient pays 100% of current fee.

___________ 14. I understand that photographs may be taken of the procedures, and hereby give my consent to those photographs being taken, as well as my consent to before and after photographs being taken. I also understand and consent to those photographs being used for and in documentation, diagnosis and treatment planning.

Patient's Signature (or Parent/Guardian):________________________________ Date: _______________

Patient's (or Parent/Guardian's) Identification: ____

Witness' Name: _______________________ Witness' Signature: __________________ Date:_________

Doctor's Signature: ____Date: ______________________

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