

**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 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 of anticipated or desired results or of the longevity of the treatment)

**Bleaching Procedure:**

**1. Minor Reduction of Tooth Structure or Permanent Restoration:** In order to access the interior of the tooth to place the bleaching material it will be necessary to make a minor reduction in the tooth or permanent restoration. This process will be done as conservatively as possible.

**2. Longevity:** It is impossible to place any specific time criteria on the length of time that the lightened appearance of whitened or bleached teeth should last. 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.

**3. Mild Discomfort:** Discomfort or pain of the treated tooth is not an anticipated result. If the patient is experiencing any discomfort, they should let this office know as soon as possible.

**Placement of Composite Resin Filling:**

**1. Aesthetics or Appearance:** Effort will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, smoking, etc. may cause the shade to change. The dentist has no control over these factors.

**2. Breakage, Dislodgement or Bond Failure:** Due to extreme masticatory pressures or other traumatic forces, it is possible for composite resin fillings or aesthetic restorations bonded with composite resins to be dislodged or fractured. The resin-enamel bond may fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

**3. Risk of Fracture:** Inherent in the placement or replacement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and placement or replacement, but may manifest at a later time.

**I understand that it is my responsibility to notify Gunnerson Dental should any undue or unexpected problems occur** or if I experience any problems relating to the treatment rendered or the services performed.

**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 this practice and/or their associates or agents to render any treatment deemed necessary, desirable, and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications. I understand it is my responsibility to inform the doctor of ALL the medications I am currently taking as well as any allergies.

## Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to use Electronic Records and Signatures.: [  ]

Relation to Patient:

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

I consent to use Electronic Records and Signatures.: [  ]