

## DISCUSSION & INFORMED CONSENT FOR COSMETIC TREATMENT

Rev 03/2018

*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. Andrew Huang, his 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. Andrew Huang 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. Referral to a prosthodontist
  - c. Referral to sleep specialist
  - d. No Treatment.
6. **Each option has been fully explained to me with it's 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. Pain 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.
8. If, during the procedure, a change in treatment is required, *including abandoning the original*

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*treatment plan if medically/professionally necessary*, 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 failure of restoration and loss of teeth due to disease.***
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. Andrew Huang, 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 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.

#### **FOR ALL PATIENTS**

I have been given the opportunity to ask questions about Cosmetic Treatment and believe that I have sufficient information to give my consent as noted below.

#### **CONSENT**

I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

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