Seitlin & Seitlin DDS
Informed Consent for Cosmetic Dentistry

Patient Name: Date of Birth:

I. Recommended Treatment

I hereby give consent to Dr. Seitlin to perform Cosmetic Dentistry on me or my dependent as follows (to be known as "Recommended Treatment"):

I give consent for this Recommended Treatment and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Treatment Alternatives

Possible alternative methods of treatment and materials and their pros and cons have been explained to me, such as: amalgam restorations or other metal-based fillings, crowns, inlays or onlays, veneers, but I wish to proceed with the Recommended Treatment described above.

III. Risks and Complications

- Drug reactions and side effects.
- Damage to adjacent teeth or tooth restorations.
- Sensitivity of teeth.
- Chipping, breaking or loosening of the restoration.
- Injury to soft tissues adjacent to restoration due to bonding or bleaching agents.
- Necessity for a more extensive restoration, such as a crown, than originally diagnosed at sometime in the future.
- Inability to exactly match adjacent tooth or teeth appearance.
- Changes in the shade, aesthetics, and appearance of the restoration, which may occur over time.
- As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.
- Changes in speech (which are usually temporary).
- Changes to the bite or position of the temporomandibular joint which may require further treatment or adjustment.

By signing, I acknowledge I have been informed about the Recommended Treatment, alternatives, and risks and I wish to proceed.

Signature:

Date:

Relationship (if patient a minor): Witness (signature):