LUMINEERS®

CERINATE One-hour Permanent Veneers

snapon smile.

PATIENT CONSENT FORM

NAME: _____
(Last) (First) (M.I)

ADDRESS: _____
(Street) (City) (State/Zip)

PHONE: _____
(Day) (Evening)

TERMS AND CONDITIONS

I understand that it is my responsibility to inform Dr._____ of any information concerning my health or mental condition that may be relevant to my care.

I have been informed about the recommended care for me, and I understand the nature of care to be:

_____

I have been informed about the possible alternative types of care, including:

_____

I understand that alternative forms of care, or no care at all, are the choices I have. The advantages and disadvantages of my choices have been presented to me.

I understand that this treatment comes with a 12 months limited warranty against manufacturing defects only.

I understand that there may be some observers in a training situation present during the performance of my treatment procedures.
I understand that I may contact Dr._____ regarding any questions or problems with my treatment.

I understand that this treatment is for a short term solution. I understand that there will be a temporary short adjustement period for the speech to go back to normal.

I have read and understand the above and do consent to care.

(If a minor, parent or legal guardian)

Patient's Signature_____ Date_____

Witness_____ Date_____

DenMat