INFORMED PATIENT CONSENT

PATIENT:_____ **DATE OF BIRTH:**_____

I hereby request and authorize Dr. _____ ("Dentist") and whomever he may designate as his assistant(s), to perform upon me the following procedure(s):

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1. I, on behalf of myself and my heirs, executors and administrators hereby release any and all claims, rights, liabilities and causes of action, known or unknown, that I may have against the above dentist and his/her staff as well as Den-Mat Holdings, LLC and its officers, directors, employees, successors and assigns arising from or related to the manufacture, supply, development and installation of a custom made dental appliance known as the Snap-On Smile for my teeth and any other procedure(s) that Dentist performs in connection therewith. As to the claims released herein, I expressly waive any rights or benefits available to me under the provisions of Section 1542 of the California Civil Code that provides:

> A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor.

2. I authorize the performance of additional procedures and changes of planned procedures if, in the judgment of Dentist, this will be necessary to improve my safety and the results contemplated by the procedure.

3. I have been provided with information by Dentist of the specific treatment planned for my case in order that I may be able to make an informed decision about the treatment. I fully understand that Dentist will use his/her best judgment and skill to accomplish the desired results. The following has been explained to me to my satisfaction, in language that I understand: my diagnosis, the anticipated procedure(s), the attendant risks and complications, alternatives, including doing nothing at all, the post-operative course, and possible variables. I understand that I am able to take as much time as I need to come to a decision whether to sign this form and to undergo the proposed treatment, and I acknowledge that I have had the opportunity to ask questions about the treatment before consenting to accept and undergo the treatment. I understand that I may stop plans for this treatment at this time or ask further questions if I desire. I also understand that there may be other doctors who are specialists in these procedures and that I have the opportunity to be treated by them and to choose alternative options to the treatment. However, I prefer to have the treatment and procedures identified above performed in this office by Dentist.

4. I understand that, although unusual, unexpected complications or less than desired results can occur, and this may result in the need for additional dental procedures, and the possibility of further expense to me.

5. I understand that excellent home care techniques, using a variety of aids, may add considerably to the successful outcome of my dental restorative program, and I understand it will be important for me to follow the home care instructions, both written and oral, very carefully. I also understand that the Snap-On Smile dental appliance is to be removed before sleeping for my personal safety as well as to extend the life of the product.

6. I understand that effort will be made to make my teeth appear as straight as possible with Snap-On Smile, but because of the existing position of my natural teeth, which are not in perfect alignment, there is no guarantee that this can be accomplished. In addition, I understand that the Snap-On Smile appliance will add minimal bulk to my teeth and that I will need to get used to the addition of the Snap-On Smile to my teeth.

By signing this informed consent form, I am confirming that I have read the above prior to signature and understand this document and the proposed treatment in full, including its possible risks, complications, and benefits, that all of my questions have been answered to my satisfaction, and that I consent to, and authorize Dentist to proceed with, the necessary treatment as proposed, following the establishment of financial arrangements. If dental insurance is involved, I understand that I am ultimately responsible for my account and any balances not covered by my insurance.

Patient Signature: _____

Date: _____