LUMINEERS®

CERINATE One-hour Permanent Veneers

snap on 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 authorize any tissues or other materials removed from me during treatment to be examined, retained, and used for general research purposes, or to be disposed of.

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 I have the right to discontinue treatment at anytime.

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

Patient's Signature_____ Date_____
(If a minor, parent or legal guardian)

Witness_____ Date_____

DenMat®