REQUEST FOR PRECISION ESTHETIC
AND RECONSTRUCTIVE DENTAL SERVICES

PATIENT_____ DATE OF BIRTH_____

I hereby request and authorize Frank Orlando, DDS FAGD and whomever he may designate as his assistant(s) and anesthesia professionals, to perform upon me the following procedure(s) and anesthesia:

_____
_____
_____
_____

1. I understand that Dr. Orlando will use his best judgment and skill to accomplish the desired results. It has been explained, in language that I understand, my diagnosis, the anticipated procedure(s), the attendant risks and complications, alternatives, including doing nothing at all, postoperative course and possible variables to my satisfaction. I have had the opportunity of asking questions and understand that I may stop plans for this treatment at this time to ask further questions if I desire. I also understand that there may be doctors who are specialists in these procedures and that I have the opportunity to be treated by them. However, I prefer to have my treatment performed in this office by Dr. Malcmacher.____

2. I do authorize the performance of additional procedures, changes or (rarely) deletion of planned procedures if, in the judgment of the doctor, this will be necessary to improve my safety and result. If any type of bone grafting is performed I assume full financial responsibility for these procedures and do not expect any type of insurance reimbursement. _____

3. Although favorable results are expected, no guarantee or warranty of expectations, refunds of any kind, either expressed, or implied, has been made. This is due to human variables associated with individual healing and responses to surgery and recovery. Likewise, I understand that, although unexpected, risks and complications can occur. The attendant risks of surgery and anesthesia have been explained to me including but not limited to possible partial or complete numbness of the lip, tongue, and cheek. I also have the opportunity to learn about unusual or rare risks and will be given information concerning this if I desire.
   _____

4. I understand that Dr. Orlando is very much involved in research and the advancement of new technologies, procedures and materials. I am also aware of the fact that several of the procedures Dr. Orlando performs are innovations in this field and may be used if Dr. Orlando feels that they will be beneficial to me and increase the chance of success._____

5. I also understand that, although unusual, an unexpected complication or less than desired result can occur, and this may result in the need for further surgery, possible hospitalization, tests, prolonged recovery, loss of work time, and the possibility of further expense to me. _____

6. I consent to the taking of clinical photographs which may be used for research, presentation and/or publications. I understand that my anonymity will be preserved. _____

7. I understand that basic veneer, crown and bridge preparation results in the considerable reduction of tooth structure when properly done. Tissue and temperature sensitivity could be experienced for an extended healing period. In some instances, root canal therapy may be required to eliminate the sensitive tissues inside the tooth. _____

8. I understand that excellent home care techniques, using a variety of aids, will add considerably to the successful outcome of my technically advanced dental restorative program, and I understand it will be important for me to follow the home care instructions, both written and oral, very carefully. _____

9. I have been informed by Dr. Orlando that it may be necessary to remove sensitive tooth structure in order to place veneers. I further understand that the dental lab and Dr. Malcmacher will do their very best to create a shade for the new crowns (s) and/or veneers that is as close as possible to the shade that I chose. I understand that the shade may not be an exact match. _____

10. I understand that effort will be made to make the teeth appear as straight as possible with veneers, 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. I also understand that veneers usually require very little tooth modification but some of my teeth, because of their present position and my bite, may require more modification than others. In addition, I understand that veneers will add minimal bulk to my teeth and that I will need to get used to the addition of the veneer porcelain to my teeth. _____

I have read the above prior to my signature and understand this document in full. I authorize Dr. Frank Orlando 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. I also state that I read and write in English.

Patient Signature: _____

If Minor, Parent or Guardian's Signature: _____