LIBBY DENTAL

Inspiring Health & Happiness

PORCELAIN RESTORATION APPROVAL

Patient Name: _____ Date: _____

I have had the opportunity to view the color and shape of the porcelain restorations prior to permanent cementation. With the expectation of the requested modifications noted below, if any, I approve the restorations to be bonded into place. I understand that certain bite adjustments might be necessary after bonding. After the bonding process, any other changes such as color and shape will require removal of the restorations which may result in further reduction of tooth structure and an additional fee.

_____ _____

Patient Signature Date

Guardian (if under 18) _____

_____ _____

Dr. Landon Libby Clinical Representative

Additional Requested Modifications

Additional requested modifications, if any, are noted as follows:

_____

_____