

Atlanta Dental Group PC
Cosmetic Dentistry with a passion for excellence! TM
www.atlantadentist.com

***Cosmetic Consultation
Information and Consent***

Thank you for choosing to visit our office. Our dentists and the entire staff warmly welcome you and hope that you will be pleased with your visit. Good communication and understanding are essential in any successful relationship so we would like to get started well by explaining exactly what this visit involves.

You are scheduled for a **Cosmetic Consultation** after **digital photographs** of your face, smile and teeth are taken. The digital photographs will be copied onto our presentation computer and edited so that they can be used for your **Smile Analysis**. You will then be invited in to our consultation area to view your images and review our findings in private. This is usually a lot of fun and most patients enjoy it.

Please be sure to understand that **this visit does not include any dental treatment**. Your visit is **limited to several digital photographs and a Cosmetic Consultation**. Our discussion with you during the Cosmetic Consultation is based upon to what we can see on your digital photographs. Digital dental photographs are great for analyzing a smile but they can not see inside the bone or gums to reveal gum disease, abscesses, cavities and a lot of other things. Because the digital photographs are limited, all final treatment recommendations must be based on a comprehensive dental examination, including dental radiographs. We hope that you will consider returning later for this necessary dental care.

The primary purpose of your Cosmetic Consultation is to give you a better understanding of what the dentists and staff at the Atlanta Dental Group PC can do for you based upon what you want to achieve with Cosmetic Dentistry.

Patient Agreement with Signature

I understand exactly what is included in my visit today and that all recommendations and fees must be finalized after a comprehensive dental examination and necessary dental radiographs. I realize that I am under no obligation to return for any treatment if I so desire.

Patient Signature: _____ Date: _____