



Consent for Crown Delivery

Crown Cementation

Patient First Name:	Patient Last Name:	DOB:	Tooth #(s):
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☐ I have had the opportunity to view the color and shape of the porcelain crown(s) under different lighting conditions. With the exception of the requested modifications noted below, if any, I approve the restorations to be bonded in place. I understand that certain bite adjustments will likely be needed after bonding in the restoration, but that other changes (e.g., relating to the color and shape) after the bonding process would likely require cutting off the crown(s), which may result in further reduction in tooth structure and an additional full fee under our current fee structure.

Signature of Patient, Parent, Guardian or Personal Representative:	Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient:
Sign	<hr/>