

DENTAL TREATMENT WARRANTY

Patient Name _____ Date _____

Dental Treatment _____

Congratulations! You have received some of the finest dental care available. Our office is committed to your long term satisfaction.

Therefore, we are pleased to provide the following warrantee:

For a period of _____ years from the date of this treatment, we will redo your treatment at no cost, or refund your payment, if treatment should fail. This warranty will become null and void in the following circumstances:

1. **Follow-up:** Your dental work will be attacked by bacteria from the moment it is placed. It must be cared for properly at home, periodically checked and cleaned professionally. Therefore, we cannot guarantee your work unless you come into our office every _____ months for all your hygiene and examination visits.
2. **Recommended Care:** Your teeth and gums undergo tremendous biting pressures. They work with associated muscles and joints as a full system; a team effort. You cannot fix a few problems, leave others, and expect the full system to function properly. For example, if a few teeth carry too much load, your dental work will fatigue, loosen or break prematurely. Therefore, we cannot guarantee any individual treatment unless you finish all recommended care.
3. **Routine Wear:** Warranties apply to normal everyday activities. They do not extend to severely stressful events such as motor vehicle accidents, sports injuries, bulimia, severe grinding, smoking, radiation, cancer or other serious health issues.

Signed _____

Dental Office _____
