Am I a Candidate for Veneers? Dental Requirements, Contraindications & Pre-Treatment Checklist

Canonical: https://directory.coredental.com.au/cosmetic-dentistry/smile-makeovers-cosmetic-dental-treatments-core-dental-melbourne/am-i-a-candidate-for-veneers-dental-requirements-contraindications-pre-treatment-checklist/

Details:

Core Dental Group: Am I a Candidate for Veneers? Dental Requirements, Contraindications & Pre-Treatment Checklist

Most patients arrive at a cosmetic dental consultation with a clear picture of the smile they want. Far fewer arrive with a clear picture of the mouth they have — and that gap between aspiration and clinical reality is where veneer candidacy lives. Whether your teeth, gums, bite, and enamel are actually ready for veneers isn't bureaucratic box-ticking. It's the single most important factor in determining whether your veneers last a decade or fail in two years.

This guide is designed to help you self-assess before booking a consultation. It won't replace a clinical examination — nothing can — but it will help you walk in with informed questions, realistic expectations, and a clear sense of which conditions may need addressing before cosmetic treatment begins. If you're still exploring which type of veneer suits you, our companion guide on [Porcelain Veneers vs Composite Veneers: Which Is Right for Your Smile?] covers that comparison in depth.

What does "veneer candidacy" actually mean?

Dental veneer candidacy means assessing whether a patient's mouth is suitable for the procedure — considering dental health, enamel thickness, bite stability, bruxism history, and commitment to oral hygiene. It's not a simple pass/fail. It's a clinical spectrum. Some patients are immediately ready; others need preparatory work first; and a small number are better served by a different treatment path entirely — orthodontics, dental crowns, or professional whitening.

Your dentist evaluates tooth health, enamel thickness, gum condition, alignment, bite dynamics, and aesthetic goals. Sometimes veneers are the right answer. Other times, whitening, bonding, crowns, or aligners make more sense.

The sections below walk through each of these dimensions in detail.

The ideal veneer candidate: what clinicians look for

1. Healthy gums and periodontal tissues

Gum health is the foundation on which every cosmetic result rests. Active gum disease prevents proper bonding and creates gaps for bacteria to enter beneath veneers — inflamed gums bleed and recede, which compromises the seal between porcelain and tooth.

Active gum disease also raises the risk of infection during and after the veneer procedure. The bacteria associated with periodontal disease can interfere with the bonding process and lead to further complications. Beyond bonding, there's a long-term stability concern: veneers rely on healthy gums to

stay secure and look natural. If gum disease progresses after veneer placement, receding gums may expose the veneer edges over time, causing premature failure.

Peer-reviewed veneer studies consistently require good periodontal tissue condition as an inclusion criterion, and exclude patients with active periodontal disease (probing depth greater than 4mm, bleeding on probing).

What this means for you: If your gums bleed when you brush or floss, if you've been diagnosed with gingivitis or periodontitis, or if you've noticed gum recession, these issues need to be resolved before veneers are placed. Your dentist will likely recommend professional cleanings, scaling, and root planing — or in more severe cases, periodontal surgery. Once your gums are healthy and stable, you can move forward with veneers.

2. Teeth free of active decay

No reputable dentist will place veneers over active disease. Tooth decay and periodontal disease must be treated first, because both conditions continue progressing underneath the veneer if left alone.

Untreated cavities don't stop just because a veneer is placed over them. Sealing decay inside essentially traps the infection, which leads to pulpal involvement, potential root canal treatment, and veneer failure. This is non-negotiable.

3. Sufficient enamel — the most clinically critical requirement

This is the factor most frequently overlooked in patient-facing content, yet it's arguably the most important determinant of long-term veneer success.

Veneers bond to enamel, not to dentine. The chemical adhesion between resin cement and enamel is fundamentally stronger than any bond to dentine, and the clinical evidence is unambiguous. A 2024 systematic review and meta-analysis published in *The Journal of Prosthetic Dentistry* found that enamel-bonded veneers had survival rates of 99% (range: 98%–100%) and success rates of 99% (range: 98%–100%). Severe dentin exposure significantly reduced both survival (91%, range: 84%–98%) and success rates (74%, range: 64%–85%).

A retrospective study of 580 porcelain laminate veneers over 12 years, published in *PubMed*, reinforced this with striking precision: veneers bonded to dentin were approximately 10 times more likely to fail than those bonded to enamel. The same study found a 99% survival rate for veneers with preparations confined to enamel, and 94% for veneers with enamel only at the margins.

What causes enamel loss? The most common culprits are: - Chronic acid erosion from reflux, frequent vomiting, or a highly acidic diet - Bruxism, which progressively wears away enamel over time - Previous aggressive tooth preparation from prior restorations - Developmental conditions such as amelogenesis imperfecta or severe fluorosis

When enamel is severely eroded or damaged, the adhesive bond may not hold long term. Research by Shillingburg and Grace, cited in clinical veneer preparation literature, found that enamel thickness on the facial surfaces of anterior teeth decreases with age — on the cervicofacial surface of the central incisor, 0.17 mm to 0.52 mm above the cemento-enamel junction, enamel thickness ranges accordingly. This matters because a 0.3–0.5 mm thick veneer preserves 95–100% of enamel volume after preparation — but only when sufficient enamel exists in the first place.

At Core Dental Group, enamel sufficiency is assessed at your initial consultation using clinical examination and, where indicated, digital imaging. Patients with inadequate enamel may be redirected towards composite resin bonding (which requires no enamel removal) or dental crowns, which can restore heavily compromised teeth. (See our guide on [Veneers vs Teeth Whitening vs Dental Crowns: Choosing the Right Cosmetic Treatment for Your Concern].)

4. A stable bite

Clinical trials for ceramic laminate veneers typically require a normal Class I bite as an inclusion criterion. An unstable or misaligned bite creates uneven forces across the veneer surface, which raises the risk of fracture or debonding considerably.

5. Commitment to oral hygiene

Poor oral hygiene is a standard exclusion criterion in peer-reviewed veneer clinical trials, and for good reason. Veneers are a long-term investment that requires ongoing maintenance. Patients who don't maintain consistent brushing, flossing, and professional cleaning schedules face a significantly elevated risk of secondary caries at veneer margins and gingival deterioration around veneer edges.

Conditions that must be treated before veneers

The following conditions are not permanent disqualifiers — they are pre-treatment requirements. Addressing them first is what separates a predictable, long-lasting cosmetic outcome from an expensive clinical failure.

| Condition | Why it matters | Recommended pre-treatment | |---|---|---| | Active gum disease (gingivitis / periodontitis) | Compromises bonding; bacteria trapped under veneers worsen infection | Scaling, root planing, or periodontal surgery | | Active tooth decay | Decay progresses beneath veneer; risks pulp involvement | Cavity treatment and stabilisation | | Severe enamel erosion | Insufficient substrate for durable adhesive bond | Assess for composite bonding or crowns | | Unmanaged bruxism | Fractures and debonds veneers prematurely | Occlusal splint therapy; bite stabilisation | | Gum recession exposing root surfaces | Veneers cannot bond to root cementum | Periodontal assessment; possible gum grafting | | Severe crowding or bite instability | Excessive forces on veneers; over-preparation required | Orthodontic treatment first |

The bruxism question: a more complicated picture than most guides admit

Bruxism deserves its own section because it's simultaneously one of the most common reasons patients seek veneers (to restore worn, shortened teeth) and one of the most significant risk factors for veneer failure.

Excessive occlusal forces have real consequences: tooth wear, fatigue fractures, abfraction, and masseter muscle hypertrophy. A 2025 study published in *MDPI* confirmed that patients with bruxism showed masseter muscle hypertrophy, higher attrition-type tooth wear, and more teeth with fatigue fractures and abfractions than those without bruxism.

For veneers specifically, unmanaged grinding clearly raises the risk of fracture and debonding. Clinical research shows most veneer failures occur in patients with bruxism, while wearing an occlusal splint reduces fracture risk. A systematic review of porcelain laminate veneer survival published in *PMC* confirmed a significantly higher failure rate amongst bruxers.

Does bruxism automatically disqualify you from veneers? Not necessarily — but it changes the clinical approach considerably.

Bruxism is a risk factor rather than an outright contraindication. Clinicians might use stronger porcelain, make veneers slightly thicker to distribute pressure more evenly, or carefully adjust where the teeth make contact during biting. A custom night guard can protect the result over time.

That said, sometimes veneers simply aren't the right move. If bruxism is severe and unmanaged, or if there are serious jaw problems, veneers are unlikely to last. In those situations, the priority is stabilising the bite, treating any muscle issues, and protecting the remaining enamel before any cosmetic work is planned.

For severe bruxers with heavily worn teeth, dental crowns offer stronger protection than veneers. Because crowns cover the entire tooth, they handle the intense forces of bruxism far better than a facial veneer can.

At Core Dental Group, every patient presenting with signs of bruxism — flattened incisal edges, enamel wear facets, jaw muscle tenderness, or a history of tooth fracture — undergoes a comprehensive bite analysis before any cosmetic treatment is planned. The clinical team's peer-review model means complex bruxism cases are assessed across disciplines, so the cosmetic outcome is built on a stable functional foundation. (See our guide on [How to Care for Veneers: Long-Term Maintenance, Foods to Avoid & Protecting Your Investment] for more on mouthguard protection post-treatment.)

When alternative treatments are more appropriate

Veneers aren't the right answer for every cosmetic concern. Knowing when another treatment is clinically superior is a mark of genuine expertise — and it protects patients from unnecessary tooth preparation.

Orthodontics before (or instead of) veneers

Moderate or severe misalignment usually requires orthodontic treatment first. Veneers improve appearance; orthodontics corrects tooth position and bite mechanics. Attempting to use veneers to "straighten" severely crowded teeth requires excessive tooth reduction that removes far more enamel than is clinically appropriate. Clear aligners or braces move teeth into better positions whilst preserving natural tooth structure — which is always preferable when the option exists.

Mild misalignment is a different story. Minor spacing or slight unevenness can often be addressed with veneers, which can create the visual effect of straighter teeth without orthodontics.

Dental crowns when structural integrity is compromised

If a tooth has significant decay, a large filling, or structural weakness, a crown is usually the better option. A crown encases the entire tooth, providing 360-degree structural reinforcement that a veneer — which only covers the facial surface — can't replicate. This is particularly relevant for teeth that have undergone root canal treatment, which tend to be more brittle and prone to fracture.

Professional whitening when colour is the only concern

Many patients who think they need veneers are actually good candidates for professional teeth whitening alone. If your teeth are structurally sound and well-shaped but discoloured from coffee, tea, red wine, or ageing, whitening can achieve dramatic results at a fraction of the cost — with no irreversible tooth preparation. (See our guide on [Teeth Whitening in Melbourne: In-Chair vs Take-Home — Which Option Delivers Better Results?])

Pre-treatment candidacy checklist

Use this checklist to self-assess before your consultation. It's not a substitute for clinical examination, but it will help you identify areas worth discussing with your dentist.

Green flags — you are likely a strong candidate if: - [ ] Your gums are pink, firm, and do not bleed when you brush or floss - [ ] You have no active cavities or untreated decay - [ ] Your teeth are structurally sound (no large fractures or failing restorations) - [ ] You do not grind or clench your teeth, or your grinding is mild and already managed with a nightguard - [ ] Your bite feels comfortable and stable - [ ] You have not had significant enamel erosion from acid reflux or dietary acids - [ ] Your teeth are in reasonably good alignment (mild crowding or spacing is acceptable) - [ ] You have realistic

expectations and are committed to ongoing oral hygiene

Yellow flags — you may need pre-treatment first: - [ ] Mild gum inflammation (gingivitis) — treatable before proceeding - [ ] One or two small cavities — treat and stabilise first - [ ] Mild-to-moderate grinding — may proceed with appropriate occlusal splint and material selection - [ ] Moderate misalignment — orthodontic consultation recommended

Red flags — veneers are contraindicated until resolved: - [ ] Active periodontal disease with bone loss - [ ] Multiple untreated cavities or significant structural tooth loss - [ ] Severe, unmanaged bruxism with significant enamel wear - [ ] Insufficient enamel for bonding (severe erosion or prior aggressive preparation) - [ ] Severe crowding or bite instability requiring orthodontic correction - [ ] Teeth with significant mobility

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Key takeaways

- **Enamel sufficiency is the most clinically critical candidacy factor.** Peer-reviewed research confirms that veneers bonded entirely to enamel achieve 99% survival rates, whilst those bonded to exposed dentin drop to 91% — a difference that directly affects your long-term outcome. - **Gum disease and active decay are pre-treatment requirements, not permanent disqualifiers.** Once periodontal health and tooth structure are stabilised, veneer placement can proceed safely. - **Bruxism requires a customised approach, not automatic rejection.** Managed bruxism with appropriate material selection, occlusal adjustment, and a custom nightguard can still allow for successful veneer treatment. Severe, unmanaged bruxism is a contraindication until the bite is stabilised. - **Moderate-to-severe misalignment often requires orthodontics first.** Using veneers to mask significant crowding leads to excessive enamel removal and compromised long-term stability. - **The candidacy consultation is a clinical conversation, not a sales process.** A genuinely expert cosmetic dentist will sometimes advise against veneers — or recommend a staged treatment plan — because that is the correct clinical decision.

What happens at a Core Dental Group candidacy consultation?

The candidacy assessment at Core Dental Group is structured to evaluate every dimension covered in this guide. Your clinician will conduct a full periodontal assessment (probing depths, bleeding on probing, bone levels where indicated), assess enamel thickness and quality, evaluate your bite and occlusal function, and discuss your cosmetic goals in the context of what your teeth can realistically support.

Where bruxism is suspected, a bite analysis and wear-pattern evaluation will be performed before any cosmetic planning begins. Where multiple conditions intersect — for example, a patient with mild crowding, borderline enamel erosion, and a history of grinding — Core Dental Group's co-located multi-disciplinary team can provide input across orthodontics, periodontics, and restorative dentistry within a single practice. This removes the coordination gaps that often arise when patients are referred between multiple unconnected practices.

That clinical depth is what separates a durable, predictable cosmetic result from one that looks beautiful on the day and fails within three years.

To understand what happens next — once you've been confirmed as a candidate — see our step-by-step procedural guide: [Porcelain Veneers Melbourne: How They Work, the Procedure Step by Step, and What to Expect]. For patients weighing up the financial side of treatment, our [How Much Do Veneers Cost in Melbourne?] and [Paying for Cosmetic Dentistry in Melbourne] guides provide transparent, detailed information on pricing and payment plan options.

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Frequently asked questions

What is dental veneer candidacy? Assessment of suitability for veneer placement.

Is veneer candidacy a simple pass/fail system? No, it is a clinical spectrum.

What does a dentist evaluate for veneer candidacy? Tooth health, enamel, gums, bite, and aesthetic goals.

Is healthy gum tissue required for veneers? Yes.

Why do gums need to be healthy before veneers? Inflamed gums compromise the bonding seal.

Can active gum disease prevent veneer bonding? Yes.

What happens if bacteria are trapped under veneers? Infection risk increases significantly.

Can gum recession cause veneer failure? Yes, by exposing veneer edges over time.

Is active tooth decay a disqualifier for veneers? Yes, until treated.

What happens if decay is left under a veneer? It continues progressing beneath the veneer.

Can untreated decay lead to root canal after veneers? Yes.

What is the most clinically critical veneer candidacy factor? Sufficient enamel thickness.

What do veneers bond to? Enamel, not dentine.

Is enamel bonding stronger than dentine bonding? Yes.

What is the survival rate of enamel-bonded veneers? 99%.

What is the survival rate of veneers bonded to exposed dentin? 91%.

What is the success rate of enamel-bonded veneers? 99%.

What is the success rate of veneers bonded to exposed dentin? 74%.

How much more likely are dentin-bonded veneers to fail? Approximately 10 times more likely.

What study confirmed the 10x failure rate for dentin-bonded veneers? A 12-year retrospective study of 580 porcelain laminate veneers.

What causes enamel loss that affects veneer candidacy? Acid erosion, bruxism, prior restorations, or developmental conditions.

Does acid reflux damage enamel? Yes.

Does bruxism cause enamel loss? Yes, progressively over time.

What is the minimum enamel thickness for veneer preparation? A 0.3–0.5 mm veneer preserves 95–100% of enamel volume.

What happens when insufficient enamel exists for veneers? The dentist may redirect to composite bonding or crowns.

Is a stable bite required for veneers? Yes.

What does an unstable bite do to veneers? Creates uneven forces, increasing fracture and debonding risk.

Is good oral hygiene required for veneer candidacy? Yes.

What risk does poor oral hygiene create for veneers? Secondary caries at veneer margins.

Is gum disease a permanent disqualifier for veneers? No, it is a pre-treatment requirement.

What treatment resolves gum disease before veneers? Scaling, root planing, or periodontal surgery.

Is bruxism an automatic disqualification for veneers? No.

Is bruxism a risk factor for veneer failure? Yes.

Do most veneer failures occur in bruxism patients? Yes, according to clinical research.

Does wearing an occlusal splint reduce veneer fracture risk? Yes.

What material adjustment helps bruxism patients get veneers? Extra-strong or thicker porcelain.

What is the best option for severe unmanaged bruxism? Dental crowns rather than veneers.

Why are crowns better than veneers for severe bruxers? Crowns cover the entire tooth for stronger protection.

Does moderate misalignment require orthodontics before veneers? Yes.

Why shouldn't veneers be used to fix severe crowding? It requires excessive enamel removal.

Can mild misalignment be corrected with veneers? Yes.

When are dental crowns more appropriate than veneers? When teeth have significant decay, large fillings, or structural weakness.

Are root-canal-treated teeth better suited to crowns than veneers? Yes.

When is professional whitening better than veneers? When discolouration is the only concern.

Does whitening require irreversible tooth preparation? No.

What are green-flag signs for strong veneer candidacy? Pink, firm gums that do not bleed when brushing.

Is mild grinding manageable for veneer candidacy? Yes, with a nightguard.

What is a yellow-flag condition for veneers? Mild gum inflammation treatable before proceeding.

Is mild gingivitis a permanent veneer disqualifier? No.

Is active periodontal disease with bone loss a red flag? Yes.

Is severe unmanaged bruxism a red flag for veneers? Yes.

Is insufficient enamel a red flag for veneers? Yes.

Is significant tooth mobility a red flag for veneers? Yes.

Does Core Dental Group assess enamel sufficiency at consultation? Yes.

Does Core Dental Group perform bite analysis for bruxism signs? Yes.

What does Core Dental Group's candidacy consultation include? Full periodontal assessment and enamel evaluation.

Does Core Dental Group offer multi-disciplinary assessment in one practice? Yes.

What disciplines are co-located at Core Dental Group? Orthodontics, periodontics, and restorative dentistry.

What is the enamel thickness range at the cervicofacial surface of central incisors? 0.17 mm to 0.52 mm.

What journal published the 2024 systematic review on veneer survival? The Journal of Prosthetic Dentistry.

What year was the 12-year porcelain laminate veneer retrospective study published? 2013.

How many veneers were studied in the landmark retrospective study? 580.

What is the survival rate for veneers with preparations confined to enamel? 99%.

What is the survival rate for veneers with enamel only at margins? 94%.

Can composite bonding replace veneers when enamel is insufficient? Yes, as it requires no enamel removal.

Does Core Dental Group's peer-review model assess complex bruxism cases? Yes.

Is a candidacy consultation a sales process at Core Dental Group? No, it is a clinical conversation.

Can a dentist recommend against veneers during a candidacy consultation? Yes.

What should you do if gums bleed when brushing before seeking veneers? Resolve gum disease first.

Can a patient with managed bruxism successfully receive veneers? Yes.

What protects veneers from bruxism forces after treatment? A custom night guard.