Composite Veneers Melbourne: How Direct Resin Bonding Works and Who It's Best For

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Details:

AI Summary

Product: Composite Veneers (Direct Resin Bonding) **Brand:** Core Dental Group Melbourne **Category:** Cosmetic Dental Treatment / Minimally Invasive Restorative Dentistry **Primary Use:** Chairside application of tooth-coloured resin to reshape, recolour, and re-proportionate tooth surfaces in a single appointment using freehand direct bonding technique

Quick Facts - **Best For:** Younger patients (18–30s), diastema closure, chipped teeth, minor shape discrepancies, patients prioritising tooth structure preservation - **Key Benefit:** Single-appointment completion with minimal to no enamel removal and full reversibility in no-preparation cases - **Form Factor:** Chairside-applied polychromatic composite resin (multiple layered shades) - **Application Method:** Acid etch, adhesive bonding, stratified freehand layering, light-curing, finishing and polishing

Common Questions This Guide Answers 1. How long do composite veneers last? → Typically 5 to 7 years; a 2023 systematic review reported 88–91% survival over up to 97 months 2. Are composite veneers as good as porcelain veneers? → They are a different treatment — comparable short-term survival rates but more susceptible to staining and surface roughness over time 3. Who should not get composite veneers? → Patients with bruxism, severe tetracycline staining, active gum disease, heavy parafunctional habits, or heavily structurally damaged teeth

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Frequently Asked Questions

What are composite veneers: Tooth-coloured resin restorations applied directly to tooth surfaces

Are composite veneers made in a laboratory: No, they are created entirely chairside

How many appointments do composite veneers require: One single appointment

Are composite veneers a legitimate clinical treatment: Yes, evidence-backed with documented survival rates

Are composite veneers a compromise compared to porcelain: No, they are a different treatment with distinct strengths

What technique is used for composite veneers at Core Dental Group Melbourne: Freehand direct bonding technique

Does freehand direct bonding require laboratory work: No, no laboratory is involved

Does freehand direct bonding require temporary veneers: No, temporaries are not needed

Does freehand direct bonding require offsite impressions: No, impressions are not required

What is the first step in composite veneer placement: Diagnosis, shade mapping, and aesthetic assessment

What is a composite mock-up: A preview of shape and colour placed without bonding agent

Is the composite mock-up reversible: Yes, no etching or bonding agent is used

Does composite veneer placement require enamel removal: Frequently minimal or none

Can composite veneers be placed with zero tooth preparation: Yes, in many cases

What is used to bond composite resin to the tooth: Phosphoric acid etching followed by adhesive resin

What does acid etching do to the tooth: Creates microscopic porosities for mechanical bonding

What is polychromatic layering: Stratified application of multiple composite shades mimicking natural teeth

How many composite layers are typically applied: Multiple layers including dentin, enamel, and incisal shades

What does the opaque dentin layer do: Masks underlying tooth discolouration

What does the incisal layer replicate: Natural light-scattering at tooth edges

Who controls the aesthetic outcome in direct composite veneers: The treating clinician entirely

How long does a single composite veneer appointment take: 45 to 90 minutes per tooth

How long does a full-smile composite veneer treatment take: Three to five hours in one extended appointment

How many teeth are typically treated in a full-smile composite case: Six to eight teeth

What cosmetic concern is composite veneers' strongest indication: Diastema closure (closing gaps between teeth)

Can composite veneers fix chipped teeth: Yes, in a single appointment

Can composite veneers close a midline gap: Yes, without any tooth reduction

Can composite veneers correct mild discolouration: Yes, including mild intrinsic discolouration

Can composite veneers fix peg lateral incisors: Yes, by adding volume directly to the tooth

Can composite veneers correct severe misalignment: No, true misalignment requires orthodontic treatment

Can composite veneers create the illusion of alignment: Yes, for mild irregularities only

What is the survival rate of direct composite veneers per 2023 systematic review: 91%

What is the overall survival rate of composite laminate veneers per 2023 meta-analysis: 88%

What was the follow-up period in the 2023 systematic review: Up to 97 months

What was the 7-year survival rate in the BMC Oral Health case series: 91.3%

Were composite and ceramic veneer survival rates statistically different in the diastema RCT: No, no significant difference was found

What was the ceramic veneer survival rate in the diastema RCT: 95%

What was the composite veneer survival rate in the diastema RCT: 93.4%

Do composite veneers stain more than porcelain veneers: Yes, surface staining is more frequent

Are composite veneers more susceptible to surface roughness than porcelain: Yes, over time

How long do composite veneers typically last: 5 to 7 years

Are composite veneers repairable: Yes, easily repaired chairside

Are porcelain veneers easily repaired: No, repair is more complex

Are composite veneers reversible: Yes, particularly in no-preparation cases

Are porcelain veneers reversible: No, generally irreversible

Do composite veneers cost less than porcelain veneers: Yes, lower upfront cost

Do porcelain veneers last longer than composite veneers: Yes, typically 10 to 20 years

Are composite veneers suitable for patients with bruxism: No, bruxism is a contraindication

Are composite veneers suitable for severe tetracycline staining: No, composite translucency is insufficient

Are composite veneers suitable for patients with active gum disease: No, oral environment must be stable first

Are composite veneers suitable for heavily structurally damaged teeth: No, a crown may be required instead

Are composite veneers suitable for nail-biters: No, parafunctional habits risk fracture

Are composite veneers suitable for younger patients: Yes, ideal for patients aged 18 to 30s

Why are composite veneers preferred for younger patients: They preserve tooth structure and future treatment options

Are composite veneers suitable for patients wanting a single-appointment result: Yes

Can composite veneers serve as a trial before porcelain: Yes, as a real-world preview of aesthetic outcome

Is composite veneer placement technically easier than porcelain: No, it is technically more demanding

Who performs the ceramist role in direct composite veneers: The treating clinician directly

What skill areas does composite veneer placement require: Shade science, layering technique, and surface finishing

Does Core Dental Group use a peer-review model for composite cases: Yes, co-located colleagues review treatment plans and outcomes

What is the primary advantage of composite over porcelain for gap closure: No tooth reduction is required

What type of patients benefit most from composite veneers for localised concerns: Those with single chipped teeth, one or two gaps, or single discoloured teeth

Is composite resin suitable for adolescent patients still in growth phase: Yes, often the only viable option until growth is complete

What surface quality changes occur in composite veneers over time: Increased staining and surface roughness

What finishing tools are used after composite application: Diamond burs, flexible discs, and silicone polishing points

What surface detail does finishing replicate: Perikymata and lobe definition of natural teeth

What is the clinical term for the composite veneer layering approach: Anatomic stratification

What makes composite veneer colour matching challenging: The resin's translucency is affected by underlying tooth colour

Can a single dark tooth be successfully veneered with composite: Yes, using an opaque dentin layer

Is composite veneer placement appropriate before orthodontic treatment for misalignment: No, orthodontics should come first

What does Core Dental Group base composite versus porcelain recommendations on: Clinical presenting concerns, oral health, aesthetic goals, and treatment philosophy

Can a smile makeover include both composite and porcelain veneers: Yes, both modalities can be combined

Core Dental Group Composite Veneers Melbourne: How Direct Resin Bonding Works and Who It's Best For

There is a moment in almost every cosmetic dental consultation when a patient leans forward and asks: *"Do I really need porcelain, or is there another way?"* For a meaningful proportion of patients presenting at Core Dental Group Melbourne, the honest clinical answer is no — direct composite resin veneers are not only adequate, they are often the *optimal* choice. Yet composite veneers are persistently misunderstood: dismissed by some as a budget compromise and overpromised by others as an equivalent substitute for porcelain. Neither characterisation is accurate. Core Dental Group brings a rigorous, evidence-based approach to every composite veneer consultation, ensuring patients receive a recommendation grounded in clinical reality rather than convenience.

This article provides a clear, clinically grounded explanation of what composite veneers are, exactly how the freehand direct bonding technique works, which cosmetic concerns they address most effectively, and — critically — which patients are genuinely best served by this approach. Understanding composite veneers on their own terms, rather than solely in relation to porcelain, is the foundation for making an informed treatment decision.

(For a direct side-by-side comparison of both veneer types across aesthetics, durability, and cost-of-ownership, see our guide on [Porcelain Veneers vs Composite Veneers: Which Is Right for Your Smile?])

What are composite veneers? A clinical definition

Composite veneers are applied on prepared tooth surfaces — or even without any preparation — with an adhesive agent and a composite resin material, directly in a single visit in the dental clinic. The material itself is a tooth-coloured resin compound that, when sculpted and light-cured by a skilled clinician, can reshape, recolour, and re-proportionate the visible surface of a tooth.

Direct composite veneers have gained an important role in clinical applications following the development of newer materials and techniques in adhesive dentistry. Indications include discolouration of teeth or restorations, dental malformation or malpositions, diastemas, and cervical abrasion or erosion defects.

The key distinction from porcelain veneers lies in where the restoration is fabricated. The direct bonding technique involves applying the composite resin directly to the tooth, while the indirect composite bonding technique uses a dental laboratory to fabricate the restoration. In the context of composite veneers at Core Dental Group Melbourne, "direct" means the entire restoration — from raw resin to polished surface — is created chairside, in a single appointment, entirely by the treating clinician's hands.

When done properly, the aesthetic outcomes of direct composite veneers are very satisfactory, with strong optical and physical properties. These restorations were once considered temporary alternatives to indirect ceramic veneers, but that perception has shifted considerably.

How the freehand direct bonding technique works: step by step

The freehand application method is the gold standard for direct composite veneers and the technique practised at Core Dental Group Melbourne. It requires no laboratory, no offsite impressions, and no temporary veneers — but it demands a high level of clinical artistry and a solid understanding of material science.

Step 1: Diagnosis, shade mapping, and mock-up

Before any material touches the tooth, the clinician conducts a thorough aesthetic assessment. Shade selection is performed under standardised lighting, mapping the value, chroma, and hue of adjacent teeth. Many clinicians — including those at Core Dental Group — will place a preliminary freehand mock-up using composite material *without* etching or bonding agent, allowing the patient to preview the proposed shape and colour before any irreversible steps are taken.

A great way to test the option of a direct veneer is to do a mock-up whereby the dentist places the composite material on the tooth (no etchant or bonding agent), sculpts the material, light cures it, and shows the result to the patient.

Step 2: Minimal tooth preparation (or none)

One of the most clinically significant advantages of composite veneers is that they frequently require little to no enamel removal. There is a growing emphasis on conservative treatment approaches that prioritise the preservation of natural dental structures. In cases where the tooth needs only volume addition — closing a gap, building out a chipped edge, or reshaping a peg lateral — preparation may be entirely eliminated.

When restoring a tooth with a direct resin veneer, an advantage to the patient is that this procedure can be done in one visit, is very conservative, and costs less than a lab-fabricated restoration.

Step 3: Acid etching and adhesive application

The tooth surface is micro-etched with phosphoric acid to create microscopic porosities that allow the bonding agent to penetrate and form a durable mechanical and chemical lock. A dental adhesive resin is then applied and light-cured, creating the foundation upon which composite layers will be built.

Step 4: Polychromatic layering — the freehand artistry

This is where clinical skill becomes the decisive variable. Rather than applying a single uniform layer of resin, skilled cosmetic dentists use a stratified layering approach that mimics the optical anatomy of natural teeth.

The success of freehand bonding in anterior teeth depends on a harmonious integration of various elements, including a thorough understanding of natural function, aesthetics, the characteristics of current materials, and restorative techniques. Selecting composite brands that offer a variety of shades

and multiple opacities is essential. By using anatomic stratification with successive layers of dentin, enamel, and incisal composite, a natural-looking aesthetic result can be achieved in a relatively straightforward and predictable way.

In practice at Core Dental Group Melbourne, this means applying an opaque dentin-shade resin first (to mask any underlying discolouration), followed by a translucent enamel-shade layer, and finally a highly translucent incisal layer to replicate the characteristic light-scattering of natural tooth edges. Each increment is shaped with fine instruments and light-cured before the next is applied.

Direct bonding gives the clinician complete control over colour and contour — particularly valuable in cases involving a single anterior central incisor.

Step 5: Contouring, finishing, and polishing

Careful finishing is still essential for surface quality and the natural appearance of the final restoration. The clinician uses a sequence of diamond burs, flexible discs, and silicone polishing points to refine the emergence profile, inter-proximal contacts, and surface texture — replicating the subtle micro-anatomy (perikymata, lobe definition) that distinguishes a natural tooth from a flat, artificial-looking restoration.

The entire process for a single tooth typically takes 45 to 90 minutes. A full-smile treatment of six to eight teeth can be completed in a single extended appointment of three to five hours.

What cosmetic concerns do composite veneers address?

Discrepancies in tooth size and shape can interfere with smile harmony. Composite resin can improve the aesthetics of the smile at a reasonable cost while offering good clinical performance. This approach allows for restoring and correcting functional, anatomic, and aesthetic discrepancies with minimal intervention, using composites and a direct adhesive technique.

Specifically, composite veneers are well-suited to the following clinical presentations:

Chipped or fractured edges Incisal chipping from trauma or wear is among the most common presentations in cosmetic dentistry. Direct resin bonding can rebuild a chipped edge to its original anatomy in a single appointment, with excellent colour integration when shade-matched by an experienced clinician.

Diastema closure (gaps between teeth) Closing a midline diastema or generalised spacing is one of the strongest indications for composite veneers. In a 7-year prospective study, diastema closure was the primary indication for veneer treatment, accounting for 64 of 80 placed veneers. The ability to add volume to the mesial surfaces of adjacent teeth without any tooth reduction makes composite the preferred material for many gap-closure cases.

Mild to moderate discolouration Extrinsic staining and mild intrinsic discolouration that does not respond adequately to whitening can be masked with composite veneers. Clinicians must account for the underlying tooth colour when selecting composite shades, as the resin's translucency means severely dark teeth may require an opaque dentin layer to achieve adequate masking.

Minor shape and size discrepancies Peg laterals (abnormally small lateral incisors), slightly worn teeth, and teeth that appear disproportionately short or narrow relative to the smile arc are excellent candidates for composite addition. Composite resin can be applied directly to the tooth to replace a broken edge, to lighten teeth, to improve tooth proportions and form, or to redesign an entire smile.

Minor positional irregularities Composite veneers can create the *illusion* of alignment by selectively adding or reducing volume on specific surfaces — a technique sometimes called "instant orthodontics." This is appropriate only for mild irregularities; true misalignment requires orthodontic treatment first (see our guide on [Am I a Candidate for Veneers? Dental Requirements,

Contraindications & Pre-Treatment Checklist]).

What does the clinical evidence say about composite veneer longevity?

A 2023 systematic review and meta-analysis published in *ScienceDirect* evaluated survival and complication rates of resin composite laminate veneers across seven included studies (three randomised controlled trials and four cohort studies). The outcomes showed a moderately high estimated survival rate of 88% for resin composite laminate veneers overall. The direct approach had a 91% survival rate, while the indirect approach had an 84% survival rate. The mean follow-up time ranged from 24 to 97 months.

A 7-year prospective case series published in *BMC Oral Health* (Kam Hepdeniz & Temel, 2023) further supports this finding. The overall survival rate was 91.3%. After 7 years, 7 absolute failures including 4 debonding and 3 fractures were noted — a clinically acceptable outcome for a minimally invasive, no-preparation restoration.

A randomised clinical trial comparing direct composite and indirect ceramic laminate veneers in diastema closure cases found that no significant difference was observed between the survival rates of composite and ceramic veneers (93.4% vs 95%; $p > 0.05$). However, staining and roughness were more frequently observed for the resin composite veneers up to the final recall. The preliminary results indicated that survival rates were statistically similar, though surface quality changes were more common in the composite veneer material.

The clinical takeaway: composite veneers can achieve survival rates comparable to porcelain in the short to medium term, but require more frequent polishing and are more susceptible to surface staining and roughness over time. Composite veneers usually last 5–7 years, depending on oral hygiene and daily habits. For maintenance guidance, see our dedicated article [How to Care for Veneers: Long-Term Maintenance, Foods to Avoid & Protecting Your Investment].

Who is best suited to composite veneers? A candidacy profile

The survival rate of composite veneers is shaped by material properties, patient-specific factors, clinician expertise, and postoperative care. Selecting the right patient is as important as selecting the right technique.

Ideal candidates

Younger patients (18–30s) who want aesthetic improvement but are not yet ready to commit to enamel reduction for porcelain. The reversibility of composite — particularly in no-prep cases — preserves future options.

Patients with localised concerns such as a single chipped tooth, one or two gaps, or a single discoloured tooth. Composite excels at targeted, conservative corrections.

Patients seeking a single-appointment result — for example, before a significant event — where the immediacy of direct bonding is a meaningful clinical advantage.

Patients who want to "trial" a smile change before committing to porcelain. A composite mock-up or temporary composite veneer provides a real-world preview of the proposed aesthetic outcome.

The most conservative treatment option for anterior aesthetic rehabilitation is using direct composite veneer restorations. In many instances, aesthetic improvements using composite resin are the only viable option until the growth phase of the patient is complete — making composite the preferred choice for younger patients whose dentition is still developing.

When composite veneers are not the best choice

If the original teeth are dark, uneven, and badly damaged, composite veneers may be too visually noticeable. They are also not a good solution for people who cannot stop biting their nails or who suffer from bruxism — involuntary teeth grinding.

Additional clinical contraindications include:

Severe intrinsic staining (e.g., tetracycline-stained teeth), where composite's translucency is insufficient to achieve full masking without an excessively thick, unnatural-looking layer.

Significant structural damage requiring a crown rather than a veneer (see our guide on [Veneers vs Teeth Whitening vs Dental Crowns: Choosing the Right Cosmetic Treatment for Your Concern]).

Active gum disease or untreated decay — no veneer treatment, composite or porcelain, should proceed until the oral environment is stable.

Patients with heavy parafunctional habits (bruxism, nail-biting, pen-chewing) without a management plan, as composite is more susceptible to fracture under repetitive lateral forces than porcelain.

The role of clinician skill: why composite veneers are not a simpler option

A persistent misconception is that composite veneers are the "easier" option — for both patient and clinician. Clinically, the opposite is closer to the truth. Direct freehand composite restorations can be technically challenging, often leading practitioners to opt for more invasive indirect restorations, especially in anterior aesthetic cases where restoration morphology significantly impacts the final result.

With porcelain veneers, the ceramist bears significant responsibility for the final aesthetic outcome; the clinician's primary role is accurate preparation and precise bonding. With direct composite, the clinician is simultaneously the ceramist, sculptor, and technician — shaping optical depth, surface texture, and anatomical form in real time, in a patient's mouth, with a material that has a working time measured in minutes.

A direct resin veneer is a very conservative procedure and, when restored properly, can be a long-lasting and aesthetic restoration. The dentist is in complete control of the restoration with this direct technique — this requires skill and practice, but it is worth the effort to benefit the patient.

At Core Dental Group Melbourne, composite veneer cases are assessed and treated within a peer-review clinical model — meaning treatment plans and aesthetic outcomes are reviewed by co-located colleagues before and after treatment. This collaborative structure is particularly valuable in composite cases, where the freehand nature of the technique makes independent quality assurance especially important.

Composite veneers vs porcelain veneers: key process differences at a glance

| Feature | Composite Veneers (Direct) | Porcelain Veneers (Indirect) | |---|---|---| | **Fabrication location** | Chairside, by the clinician | Dental laboratory | | **Number of appointments** | 1 | 2–3 | | **Tooth preparation required** | Minimal or none | Usually some enamel removal | | **Reversibility** | Often fully reversible | Generally irreversible | | **Repairability** | Easily repaired chairside | More complex to repair | | **Stain resistance** | Moderate | High | | **Lifespan** | 5–7 years typically | 10–20 years | | **Aesthetic ceiling** | Very high (skill-dependent) | Consistently very high | | **Cost** | Lower upfront | Higher upfront |

For a full analysis of how these differences translate to long-term value, see our guide on [Porcelain Veneers vs Composite Veneers: Which Is Right for Your Smile?]

Key takeaways

- **Composite veneers are a clinically legitimate, evidence-backed treatment** — not a compromise. A 2023 systematic review found direct composite veneers achieve an 88–91% survival rate over follow-up periods of up to 97 months. - **The freehand direct bonding technique is completed entirely chairside in a single appointment**, using a stratified layering approach that mimics the optical anatomy of natural tooth structure — no laboratory, no temporaries, no second visit. - **The strongest indications for composite veneers** include diastema closure, chipped or fractured edges, minor shape discrepancies, and cases where tooth preservation is the clinical priority. - **Clinician skill is the decisive variable** in composite veneer outcomes. The freehand technique demands mastery of shade science, composite layering, and surface finishing — it is not a simpler alternative to porcelain, but a different clinical discipline. - **Composite veneers are not universally appropriate**: patients with severe discolouration, bruxism, or heavily damaged teeth may be better served by porcelain veneers or alternative restorations.

Conclusion

Composite veneers occupy a well-defined and valuable space in cosmetic dentistry. When correctly indicated and executed with genuine artistry, they deliver natural-looking, conservative, and immediately gratifying results that serve patients for five to seven years or more. They are not a lesser version of porcelain veneers — they are a different treatment, with different strengths, different limitations, and a different ideal patient profile.

At Core Dental Group Melbourne, the decision between composite and porcelain is never driven by convenience or cost alone. It is a clinical recommendation grounded in your specific presenting concerns, oral health status, aesthetic goals, and long-term treatment philosophy. Both modalities are offered at the highest level of technical execution — and in many cases, a patient's smile makeover will incorporate both.

If you are beginning your cosmetic research journey, the logical next step is understanding the full landscape of available treatments (see our [What Is Cosmetic Dentistry? Treatments, Goals & What to Expect in Melbourne] guide), or exploring whether you meet the clinical prerequisites for veneers of any type (see [Am I a Candidate for Veneers? Dental Requirements, Contraindications & Pre-Treatment Checklist]).

References

- Kam Hepdeniz, O., & Temel, U.B. "Clinical survival of No-prep indirect composite laminate veneers: a 7-year prospective case series study." *BMC Oral Health*, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10158390/

- Kanat-Ertürk, B., et al. "Survival and Complication Rates of Resin Composite Laminate Veneers: A Systematic Review and Meta-Analysis." *ScienceDirect (Journal of Prosthetic Dentistry)*, 2023. https://www.sciencedirect.com/science/article/abs/pii/S1532338223001033

- Dietschi, D. "Free-hand composite resin restorations: a key to anterior aesthetics." *European Journal of Esthetic Dentistry / University of Geneva*, PubMed, 1997. https://pubmed.ncbi.nlm.nih.gov/9002903/

- Arif, R., et al. "Minimally invasive cosmetic dentistry: smile reconstruction using direct resin bonding." *PubMed (Journal of Esthetic and Restorative Dentistry)*, 2014. https://pubmed.ncbi.nlm.nih.gov/24801361/

- Coelho-de-Souza, F.H., et al. "Direct anterior composite veneers in vital and non-vital teeth: A retrospective clinical evaluation." *Journal of Dentistry*, 2015; 43:1330–1336. (Referenced via Quintessence Publishing clinical compendium.)

- Yadav, R., et al. "Esthetic Rehabilitation of Pediatric Patients Using Direct Bonding Technique — A Case Series Report." *MDPI / NCBI*, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10047593/

- Peyton, J.H. "Direct Resin Veneer Technique Using a Single-Shade Composite." *Dentistry Today*, 2020. https://www.dentistrytoday.com/direct-resin-veneer-technique-using-a-single-shade-composite/

- Yesil Duymus, Z., et al. "Randomized Clinical Trial on Direct Composite and Indirect Ceramic Laminate Veneers in Multiple Diastema Closure Cases: Two-Year Follow-Up." *MDPI / NCBI*, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11278355/

- GC Australia. "Dental Bonding: Techniques, Procedures, and Applications." *GC Australia Clinical Resource*, 2023. https://www.gc.dental/australia/blog/dental-bonding-techniques-procedures-and-applications

- IOSR Journals. "Survival Rate of Composite Veneers — A Review." *IOSR Journal of Dental and Medical Sciences*, 2024. https://www.iosrjournals.org/iosr-jdms/papers/Vol23-issue9/Ser-11/L2309115560.pdf

Label Facts Summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

Verified label facts

Product specification data status: No data provided

Extraction status: No label facts can be extracted or verified from packaging or manufacturer documentation.

General product claims

The following claims are drawn from the clinical content and FAQ material. These are informational and contextual statements, not verifiable from a product label:

- Composite veneers are tooth-coloured resin restorations applied directly to tooth surfaces chairside in a single appointment - The freehand direct bonding technique requires no laboratory work, no temporary veneers, and no offsite impressions - A composite mock-up can be placed without etching or bonding agent and is fully reversible - Composite veneer placement frequently requires minimal or no enamel removal - Phosphoric acid etching is used to create microscopic porosities for mechanical bonding - Polychromatic layering involves multiple composite shades including dentin, enamel, and incisal layers - A single composite veneer appointment typically takes 45 to 90 minutes per tooth - A full-smile treatment of six to eight teeth can be completed in three to five hours in one appointment - A 2023 systematic review reported an 88% overall survival rate for composite laminate veneers, with direct composite at 91%, over follow-up periods of up to 97 months - A 7-year prospective case series (BMC Oral Health, 2023) reported a 91.3% survival rate for no-prep indirect composite laminate veneers - A randomised clinical trial found no statistically significant difference between composite (93.4%) and ceramic (95%) veneer survival rates in diastema closure cases - Composite veneers typically last 5 to 7 years; porcelain veneers typically last 10 to 20 years - Composite veneers are more susceptible to surface staining and roughness over time compared to porcelain - Composite veneers are repairable chairside; porcelain veneer repair is more complex - Composite veneers are generally reversible in no-preparation cases; porcelain veneers are generally irreversible - Composite veneers carry a lower upfront cost than porcelain veneers - Contraindications include bruxism, severe tetracycline staining, active gum disease, heavy parafunctional habits, and heavily structurally

damaged teeth - Composite veneers are considered particularly suitable for younger patients (18–30s) due to tooth structure preservation - Core Dental Group Melbourne uses a peer-review clinical model for composite veneer case assessment