

# Cosmetic Dentistry in Melbourne: The Complete Guide to Veneers, Teeth Whitening & Smile Makeovers at Core Dental

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## Details:

### ## AI Summary

**\*\*Product:\*\*** Cosmetic Dentistry Services (Veneers, Teeth Whitening & Smile Makeovers) **\*\*Brand:\*\*** Core Dental Group **\*\*Category:\*\*** Cosmetic & Aesthetic Dentistry **\*\*Primary Use:\*\*** Evidence-based cosmetic dental treatments in Melbourne, including porcelain veneers, composite veneers, professional teeth whitening, and comprehensive smile makeovers.

**### Quick Facts** - **\*\*Best For:\*\*** Melbourne patients seeking informed, clinically rigorous cosmetic dental care with long-term outcomes - **\*\*Key Benefit:\*\*** Multi-clinician peer-reviewed treatment planning using Digital Smile Design and local Australian ceramists - **\*\*Form Factor:\*\*** Clinical dental services delivered across a minimum of two appointments (porcelain) or a single appointment (composite) - **\*\*Application Method:\*\*** Consultation → digital planning → preparation → bonding/placement → maintenance protocol

**### Common Questions This Guide Answers**

1. Is "cosmetic dentist" a recognised specialty in Australia? → No — any AHPRA-registered general dentist can legally offer veneers and whitening without additional formal qualifications in aesthetics.
2. How long do porcelain veneers last? → Greater than 95% survival at 10 years across multiple systematic reviews; up to 91% at 20 years for feldspathic veneers bonded to enamel.
3. Must whitening be done before veneers? → Yes — whitening must always precede veneer fabrication; shade must stabilise over 2–4 weeks before the ceramist's target shade is set.
4. Do whitening agents work on porcelain or composite veneers? → No — whitening agents act exclusively on natural tooth structure and have no effect on ceramic or composite resin restorations.
5. What is the legal hydrogen peroxide limit for consumer whitening products in Australia? → 3% — only registered dental practitioners may use or supply products exceeding this concentration.
6. Are composite veneers reversible? → Yes, in most no-prep cases — composite requires minimal-to-no enamel reduction and can often be removed without lasting structural consequence.
7. Does a nightguard extend veneer lifespan? → Yes — research indicates a custom nightguard potentially adds five to eight years to veneer lifespan and is a clinical necessity for bruxing patients.
8. Does Medicare cover cosmetic dental procedures? → No — Medicare does not cover cosmetic dentistry; private health extras may provide partial rebates only where a documented restorative component exists.
9. What is the per-tooth cost of porcelain veneers in Melbourne? → \$1,200–\$2,500 AUD per tooth, with mid-range clinics averaging \$1,700–\$1,900 AUD as of 2025/2026.
10. Is bruxism an absolute contraindication for veneers? → No — it is a significant risk factor that changes the clinical approach, including mandatory nightguard use and possible preference for crowns in severe cases.

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## ## Executive summary

Cosmetic dentistry in Melbourne has never been more sophisticated — or more confusing for patients trying to navigate it. The same city that offers world-class ceramists, Digital Smile Design technology, and multi-disciplinary clinical teams also has practices where any registered general dentist can offer porcelain veneers without additional formal qualification in aesthetics. The gap between the best and the rest is wide, and the consequences of choosing poorly are permanent.

This guide is the definitive clinical and practical resource for anyone considering cosmetic dental treatment at Core Dental Group. It draws together the full breadth of our content — from the foundational science of what cosmetic dentistry actually is, through the mechanics of porcelain and composite veneers, professional teeth whitening, and complete smile makeovers, to candidacy assessment, long-term maintenance, treatment costs, and how to choose a clinician you can trust.

What makes this page different from a treatment menu is its cross-cutting analysis: the connections between subtopics that individual articles cannot make. Why does the enamel substrate question matter to both your veneer candidacy and your long-term survival statistics? Why must whitening always precede veneer fabrication in a combined case? How does the bruxism question intersect with material selection, candidacy, maintenance, and cost-of-ownership simultaneously? These are the questions that define real clinical decision-making — and they are answered here, with evidence.

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## ## Part 1: What cosmetic dentistry actually is — and why the definition matters

### ### The clinical discipline behind the aesthetic goal

Cosmetic dentistry is best understood not as a list of procedures but as a clinical discipline that applies artistic principles to dental treatment — addressing the colour, shape, size, proportion, and alignment of teeth to produce outcomes that are simultaneously visually harmonious and functionally sound. The discipline spans a spectrum from a single whitening session to a full-arch smile makeover involving six or more treatment modalities delivered across multiple months.

One of the most important things any Melbourne patient can understand before booking a consultation: "cosmetic dentist" is **not a recognised specialty** under the Australian Health Practitioner Regulation Agency (AHPRA) framework. The Dental Board of Australia works to ensure that Australia's dental practitioners are suitably trained, qualified and safe to practise, and has recently strengthened protections for patients seeking non-surgical cosmetic procedures. Yet any AHPRA-registered general dentist can legally offer porcelain veneers, smile makeovers, and whitening without additional formal qualifications in aesthetics. Medicine, dentistry and podiatry have approved specialist titles — a practitioner who uses these titles has additional training and qualifications in a specialty field — but "cosmetic dentist" is not among them.

This regulatory reality makes patient education the single most important protective factor in the Melbourne market. Understanding the discipline, not just the treatment menu, is what separates patients who make confident, well-informed decisions from those guided entirely by social media aesthetics and per-tooth price comparisons.

### ### Cosmetic vs. restorative dentistry: the overlap that changes everything

The distinction between cosmetic and restorative dentistry matters clinically because it affects health fund rebates, treatment priority, and clinical sequencing. Restorative dentistry addresses function — cavities, fractures, missing teeth. Cosmetic dentistry addresses appearance — colour, shape, proportion. But the clinical reality is rarely so clean.

A porcelain crown placed to protect a heavily cracked tooth is restorative in intent and cosmetic in outcome. A veneer placed over a discoloured but structurally sound tooth is cosmetic in intent but may provide marginal structural benefit. This intersection — sometimes called aesthetic restorative dentistry — is where the most sophisticated clinical work happens, and it is where Core Dental Group operates.

The clinical rule at Core Dental Group is non-negotiable: health before aesthetics. Active decay, gum disease, bite instability, or unmanaged bruxism must be diagnosed and treated before cosmetic work begins. Placing veneers over unhealthy teeth is not just clinically inappropriate — it undermines the longevity and integrity of the cosmetic result, and it is one of the primary reasons veneer treatments fail prematurely.

\*(For a complete overview of what cosmetic dentistry encompasses and how to set realistic expectations, see our foundational article: **\*\*What Is Cosmetic Dentistry? Treatments, Goals & What to Expect in Melbourne\*\***.)\*

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## Part 2: The science of porcelain veneers — evidence, procedure & what actually happens to your teeth

### Why porcelain remains the gold standard

Porcelain laminate veneers (PLVs) are thin ceramic shells — typically 0.5 to 0.7 mm thick — permanently bonded to the front surfaces of prepared teeth to transform their colour, shape, and proportion. They are the flagship treatment in cosmetic dentistry for a reason grounded in decades of clinical evidence, not marketing.

A 2024 narrative literature review found that dental veneers generally have a high survival rate — greater than 90% for more than 10 years — and that the amount of preserved enamel plays a paramount role in survival and success rates, with glass-ceramic veneers with minimal or no preparation showing the highest survival rates.

The 2024 systematic review and meta-analysis by Klein et al., published in the *\*Journal of Esthetic and Restorative Dentistry\** — drawing on 29 studies with a last search date of February 2024 — found pooled survival rates of: - **\*\*96.13% for feldspathic veneers\*\*** - **\*\*93.70% for leucite-reinforced glass ceramics\*\*** - **\*\*96.81% for lithium disilicate veneers\*\***

at 10.4 years of follow-up. These figures are consistent with the earlier landmark systematic review by Morimoto et al. (2016), which analysed 6,500 porcelain laminate veneers across 25 studies and found a 10-year estimated cumulative survival rate of 95.5%.

A study by Layton and Walton (2011) demonstrated a 96% survival rate at 10 years and 91% at 20 years for feldspathic porcelain veneers bonded to enamel — a finding that underscores the critical importance of the bonding substrate, discussed below.

### The enamel substrate: the single most important variable in veneer longevity

This is the cross-cutting clinical insight that connects the porcelain veneer procedure, candidacy assessment, and long-term maintenance into a single coherent story — and it is the factor most frequently overlooked in patient-facing content.

Porcelain veneers bond to enamel, not to dentine. The adhesive chemistry between resin cement and enamel is fundamentally stronger than any bond to dentine, and the clinical evidence on this point is consistent across study designs.

Research has rejected the hypothesis that no differences would be found in survival and complication rates when ceramic veneers are bonded to different substrates — significant differences were found in success and survival rates across varying substrates.

A 2024 retrospective clinical study published in the *Journal of Esthetic and Restorative Dentistry*\* (Etienne et al.) followed 672 veneers in 189 patients for 1 to 15 years, categorising veneer-supporting teeth after etching based on the degree of dentin exposure into three groups: enamel only, less than 30% dentin, and greater than 30% dentin. The survival differential between enamel-only and high-dentin-exposure cases was clinically striking.

This enamel-substrate principle has direct implications for three separate questions every veneer patient should ask:

1. **\*\*Am I a candidate?\*** Patients with severe acid erosion, advanced bruxism-related wear, or developmental enamel deficiencies may not have sufficient enamel for durable bonding — redirecting them toward composite bonding or crowns. 2. **\*\*How much preparation is appropriate?\*** Preparation depths of 0.4–0.7 mm — within enamel — are not just about conservatism; they directly predict survival. Fracture is the primary failure mechanism associated with decreased survival rate, followed by debonding and colour change, and fractures increase in the presence of parafunctional activities. 3. **\*\*How long will they last?\*** The patient who maintains enamel integrity through conservative preparation, proper maintenance, and a custom nightguard (if they grind) will almost certainly achieve the upper end of the 10–20 year longevity range.

### The procedure: what actually happens at each appointment

The porcelain veneer process at Core Dental Group spans three stages: consultation and digital planning, tooth preparation and temporaries, and bonding. The waiting period between preparation and bonding is laboratory fabrication time, not a separate clinical stage.

**\*\*Stage 1 — Consultation and Digital Smile Design:\*** Core Dental Group's clinicians assess oral health baseline, photograph and digitally map the smile, discuss shade and shape, and plan preparation depth. The proposed treatment plan is reviewed across the clinical team before the patient leaves — a peer-review model that provides a structural quality-assurance layer unavailable in single-clinician practices.

Across all included studies in a 2025 systematic review of Digital Smile Design (DSD), DSD consistently improved patient satisfaction, treatment acceptance, communication, and perceived predictability compared with conventional approaches, with quantitative evidence showing significantly higher satisfaction scores and superior aesthetic and functional ratings in DSD-guided treatments.

**\*\*Stage 2 — Preparation and temporaries:\*** The most misunderstood appointment in cosmetic dentistry. Social media has propagated the image of teeth "shaved to pegs" — a confusion between crown preparation (which removes 63–72% of coronal tooth structure) and veneer preparation (which removes only 3–30%). Preparation is guided by a silicone index fabricated from the pre-operative wax-up, ensuring the clinician removes exactly the right amount — no more, no less. Temporary veneers are placed immediately, protecting prepared teeth and giving patients a real-world preview of the proposed shape and length before final ceramics are manufactured.

**\*\*Stage 3 — Bonding:\*** Adhesive cementation is where the clinical precision of the procedure culminates. The tooth surface is etched, a bonding agent applied, and the veneer seated with a dual-cure resin cement. Occlusion is checked and refined. At Core Dental Group, laboratory selection is taken seriously — cases are sent to skilled local Australian ceramists with whom the clinical team has an established working relationship, not offshore laboratories where quality control and communication are harder to verify.

\*(For the complete step-by-step clinical walkthrough, see our dedicated article: **\*\*Porcelain Veneers Melbourne: How They Work, the Procedure Step by Step, and What to Expect\*\***.)\*

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## Part 3: Composite veneers — when direct resin is the optimal choice

### ### Not a budget compromise: a clinically valid modality

Composite veneers are persistently mischaracterised in online content — dismissed by some as a budget compromise, overpromised by others as equivalent to porcelain. Neither characterisation is accurate. Direct composite resin veneers are a clinically validated, evidence-supported treatment modality with a specific and well-defined set of ideal indications.

A 2023 systematic review and meta-analysis published in *ScienceDirect* evaluated survival and complication rates of resin composite laminate veneers across seven included studies and found an overall estimated survival rate of 88%, with the direct approach achieving 91%. A 7-year prospective case series published in *BMC Oral Health* (Kam Hepdeniz & Temel, 2023) reported an overall survival rate of 91.3% at seven years for no-preparation direct composite veneers.

These are not trivial numbers. For a minimally invasive, single-visit restoration that requires no enamel removal in most cases, an 88–91% survival rate at 5–7 years is a genuinely strong clinical track record — particularly for the patient populations for whom composite is most appropriate.

### ### The freehand direct bonding technique: where artistry becomes clinical skill

The freehand application method is the gold standard for direct composite veneers and the technique practised at Core Dental Group. It requires no laboratory, no impressions sent offsite, and no temporary veneers — but it demands a level of clinical artistry that makes the clinician's skill the single most decisive variable in the outcome.

The technique proceeds through five stages: shade mapping and mock-up (often placed without etching so the patient can preview the result); minimal or no tooth preparation; acid etching and adhesive application; polychromatic layering using dentin, enamel, and incisal composite shades to replicate the optical anatomy of natural teeth; and meticulous finishing and polishing to replicate natural surface micro-anatomy.

A full-smile treatment of six to eight teeth can be completed in a single extended appointment of three to five hours — a genuine clinical advantage for patients with an upcoming event or a tight schedule.

### ### The ideal composite veneer candidate

The following patient profiles represent the strongest clinical indications for direct composite resin:

- **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 treatment options.
- **Patients with localised concerns** — a single chipped tooth, one or two gaps, a single discoloured tooth. Composite excels at targeted, conservative corrections.
- **Diastema closure cases** — in a 7-year prospective study, gap closure was the primary indication for composite veneer treatment, accounting for 64 of 80 placed veneers.
- **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.

Composite veneers are not the best choice when intrinsic discolouration is severe (dark teeth will show through resin), when the patient has unmanaged bruxism, or when a comprehensive full-smile transformation across 8–10 teeth is the goal — where porcelain's superior optical properties, stain resistance, and longevity provide a measurably better long-term outcome.

\*(For a complete clinical guide to the freehand technique and candidacy assessment, see: **Composite Veneers Melbourne: How Direct Resin Bonding Works and Who It's Best For**.)\*

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### ## Part 4: Porcelain vs. composite — the evidence-based decision framework

### ### Seven dimensions that actually matter

The porcelain vs. composite decision is the most consequential choice most cosmetic dental patients make, yet it is routinely oversimplified. Here is the cross-cutting analysis that individual articles cannot provide — a synthesis of all seven dimensions simultaneously.

**\*\*1. Aesthetics:\*\*** Porcelain's optical behaviour — its ability to interact with light in a way that closely resembles natural enamel — gives it a measurable aesthetic advantage, particularly across a full set of anterior teeth where the eye compares multiple restorations simultaneously. In the hands of a highly skilled clinician using premium nano-hybrid resins, composite can produce impressive results for single-tooth corrections.

**\*\*2. Longevity:\*\*** The evidence is consistent. Porcelain veneers achieve 10-year survival rates of 95%+ across multiple systematic reviews. Composite veneers achieve 88–91% survival at 5–7 years. A landmark 10-year practice-based retrospective study found that composite veneers presented a higher risk of failure than ceramic veneers, with a hazard ratio for survival of 4.00 and for success of 5.16 — though both treatments still delivered high survival rates and may be used in clinical practice.

**\*\*3. Reversibility:\*\*** Porcelain preparation removes 3–30% of coronal tooth structure and is, in most cases, permanent. Composite veneers typically require minimal-to-no tooth reduction and can, in many cases, be removed or revised without lasting structural consequence. This makes composite a genuinely reversible option — a decisive advantage for younger patients or those uncertain about permanence.

**\*\*4. Stain resistance:\*\*** Porcelain's glazed ceramic surface does not absorb pigments from food and drinks. Colour change is among the primary failure mechanisms for composite veneers, and clinical trials consistently found that staining and roughness were more frequently observed for resin composite veneers up to the final recall. For patients who regularly consume coffee, red wine, or tea, this differential is clinically important.

**\*\*5. Repairability:\*\*** Composite veneers can be repaired chairside in a single appointment. Porcelain veneers, being rigid ceramic, typically require full replacement when significantly fractured. However, porcelain veneers — when well-maintained — are far less likely to need repair in the first place.

**\*\*6. Speed:\*\*** Composite veneers are completed in a single appointment. Porcelain veneers require a minimum of two appointments separated by 1–3 weeks of laboratory fabrication time.

**\*\*7. Annualised cost:\*\*** This is the most overlooked dimension. A full composite veneer treatment at \$650 AUD/tooth × 8 teeth = \$5,200 AUD upfront, replaced at year 6 and again at year 12 = approximately \$15,600 AUD over 15 years. Porcelain veneers at \$1,800 AUD/tooth × 8 teeth = \$14,400 AUD upfront, with survival rates exceeding 90% after a decade and many lasting well beyond 15 years. The per-year cost of porcelain frequently becomes comparable or superior over a patient's lifetime — a calculation that upfront price comparisons completely obscure.

\*(For the complete head-to-head comparison with clinical data tables, see: **\*\*Porcelain Veneers vs Composite Veneers: Which Is Right for Your Smile?\***)\*

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### ## Part 5: Professional teeth whitening — the science, the options, and the regulatory context

#### ### Why professional whitening outperforms everything you can buy at a pharmacy

Professional teeth whitening is the most accessible entry point into cosmetic dentistry — non-invasive, reversible, and capable of producing dramatic aesthetic improvements in a single appointment or across a few weeks at home. The mechanism is well-established: peroxide-based bleaching agents penetrate enamel and dentine, oxidising the organic compounds responsible for tooth discolouration and converting them into lighter, less visible molecules.

The critical regulatory context for Melbourne patients: on the grounds of public safety, only registered dental practitioners who are educated, trained and competent in teeth whitening procedures should use or supply teeth bleaching products containing more than 3% hydrogen peroxide or equivalent. In August 2021, the Board published guidance for registered dental practitioners on using and supplying teeth whitening products, citing the Poisons Standard, Therapeutic Goods Administration (TGA) advertising requirements, and Australian Consumer Law.

This regulatory ceiling on consumer products is the single most important reason why professional whitening outperforms anything purchased from a pharmacy shelf. Research has found that the maximum effect achieved by all OTC bleaching agents was the removal of stains, whereas hydrogen peroxide was capable of further whitening the teeth. OTC products can produce modest improvement in surface staining, but they cannot achieve the depth of colour change that professionally supervised treatment delivers.

### ### In-chair vs. take-home: the clinical tradeoff

Both in-chair and take-home professional whitening use peroxide chemistry. The key variables are concentration, speed, and sensitivity profile.

In-chair whitening uses hydrogen peroxide concentrations of approximately 25–35%, delivering up to 5–6 shades of whitening in a single 60–90 minute appointment. It suits event-driven patients, those with severe extrinsic staining, and patients who struggle with compliance. The primary clinical trade-off is a higher incidence of transient tooth sensitivity — exceeding 87% in some studies.

Take-home professional whitening uses lower concentrations (9.5% hydrogen peroxide or 10–16% carbamide peroxide) delivered via custom-fitted trays over 10–14 days. The carbamide peroxide option is gentler on sensitive teeth and allows patients to manage their whitening incrementally. The advantages are lower sensitivity rates and the ability to top up and control the degree of whitening over time.

The most effective long-term strategy — commonly used at Core Dental Group — is a combined approach: in-chair whitening for an immediate, dramatic result, followed by periodic take-home top-ups. Clinical research shows that after one in-office bleaching session, there was no difference in whitening effectiveness between performing a second in-office session and using one week of at-home bleaching — meaning the take-home component is clinically equivalent to a second in-chair session for maintenance purposes.

### ### The critical sequencing rule: whitening before veneers

This is one of the most important cross-cutting principles in this entire guide — and one that connects the whitening and veneer sections in a way that individual articles cannot fully convey.

Whitening agents have no effect on ceramic, composite resin, or porcelain restorations. They work exclusively on natural tooth structure. In any combined whitening-and-veneer case, whitening must always be completed first, the shade must be allowed to stabilise over 2–4 weeks, and the veneer shade is then selected to match the newly brightened natural teeth. If veneers are fabricated before whitening, the clinician is forced to match the pre-whitening shade — and any subsequent whitening will lighten the natural teeth without affecting the ceramic, creating a visible mismatch across the smile.

This sequencing principle also means that patients with existing porcelain crowns or composite fillings on their front teeth cannot whiten those restorations — only their natural tooth structure will respond, potentially creating a colour mismatch that requires professional intervention to resolve.

\*(For the complete clinical comparison of both whitening methods, see: **\*\*Teeth Whitening in Melbourne: In-Chair vs Take-Home — Which Option Delivers Better Results?\*** For post-whitening maintenance, see: **\*\*Teeth Whitening Aftercare: How to Maintain a Whiter Smile and Extend Your**

Results\*\*.)\*

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## ## Part 6: Smile makeovers — the architecture of comprehensive transformation

### ### What a smile makeover actually is

A smile makeover is not a single treatment. It is a clinically sequenced treatment plan where the order of each step directly determines the quality and longevity of the final result. It may combine whitening, composite bonding, porcelain veneers, crown lengthening, orthodontics, and ceramic crowns — coordinated across multiple appointments and, at Core Dental Group, across multiple clinicians.

The distinction between a smile makeover and a collection of procedures is planning rigour. Before any instrument touches a tooth, Core Dental Group's clinicians evaluate six interconnected aesthetic dimensions: facial proportions and midline alignment; tooth shape, length, and width ratios; gum line architecture; bite function and occlusion; tooth colour and shade mapping; and lip dynamics and smile arc. Each dimension influences the others, which is why they must be assessed simultaneously rather than in isolation.

### ### Digital Smile Design and the mock-up: seeing your result before it's permanent

A 2025 systematic review evaluated the influence of Digital Smile Design (DSD) on patient-centred outcomes including satisfaction, aesthetic perception, quality of life, and psychosocial impact, with a comprehensive search of PubMed/MEDLINE, ScienceDirect, Google Scholar, and the Cochrane Library performed from inception to August 2025, following PRISMA guidelines.

Across all included studies, DSD consistently improved patient satisfaction, treatment acceptance, communication, and perceived predictability compared with conventional approaches. Studies with follow-up data also reported stable long-term outcomes and improved self-confidence among patients.

The physical mock-up — a temporary, reversible application of composite resin placed directly over existing teeth to simulate the proposed final result — is perhaps the most underappreciated step in any smile makeover. Research shows that mock-up-guided preparations preserved an average of 25–30% more tooth structure compared to freehand preparations, contributing to improved long-term biological outcomes in aesthetic veneer cases. At Core Dental Group, patients wear the mock-up, speak, smile, eat, and live with it — often for several days — before any irreversible steps are taken.

### ### The treatment sequencing logic

Treatments in a Core Dental Group smile makeover are delivered in a clinically logical order:

1. **Periodontal and gum health stabilised first** — inflamed gums bleed and recede, compromising the bonding seal between porcelain and tooth
2. **Orthodontic alignment completed** (if required) — veneers cannot correct significant crowding without excessive enamel removal
3. **Crown lengthening or gum contouring** (if required) — allowed to heal before restorations are fabricated
4. **Whitening completed and shade stabilised** — the ceramist's target shade is established
5. **Restorations fabricated and placed** — veneers, crowns, and bonding in coordinated sequence
6. **Review and maintenance** — post-treatment occlusal assessment and long-term care protocols established

This sequencing is not administrative formality — it is the clinical mechanism by which a smile makeover achieves a result that is simultaneously beautiful, functional, and lasting.

\*(For the complete smile makeover planning process, see: **What Is a Smile Makeover? How Core Dental Group Designs Your Complete Smile Transformation**.)\*

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## ## Part 7: Candidacy, contraindications & the bruxism question

### The clinical assessment every patient needs first

Veneer candidacy is not a binary pass/fail system. It is a clinical spectrum. Some patients are immediately ready; others need preparatory treatment first; and a small number will be better served by an entirely different treatment. The assessment covers five domains:

**\*\*Gum health:\*\*** Active periodontal disease prevents proper bonding and creates gaps for bacteria to enter beneath veneers. Inflamed gums bleed and recede, compromising the bonding seal. This is a pre-treatment requirement, not a permanent disqualifier.

**\*\*Decay status:\*\*** No reputable dentist will place veneers over active decay. A veneer bonded over a decayed tooth seals the infection inside, leading to pulpal involvement, potential root canal treatment, and veneer failure.

**\*\*Enamel sufficiency:\*\*** As established in Part 2, enamel-bonded veneers achieve near-perfect survival rates. Patients with severe acid erosion, advanced bruxism-related wear, or developmental enamel deficiencies may not have sufficient enamel substrate for durable bonding. At Core Dental Group, enamel sufficiency is assessed at the initial consultation using clinical examination and, where indicated, digital imaging.

**\*\*Bite stability:\*\*** An unstable or misaligned bite creates uneven forces across the veneer surface, dramatically increasing the risk of fracture or debonding. Clinical trials for ceramic laminate veneers typically require a normal bite (Class I) as an inclusion criterion.

**\*\*Oral hygiene commitment:\*\*** Poor oral hygiene is a standard exclusion criterion in peer-reviewed veneer clinical trials. Patients who do not maintain consistent brushing, flossing, and professional cleaning schedules face significantly elevated risk of secondary caries at veneer margins.

### The bruxism question: risk factor, not automatic disqualifier

Bruxism deserves its own discussion because it simultaneously represents 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. Fracture is the primary failure mechanism associated with decreased survival rate for dental veneers, and fractures increase in the presence of parafunctional activities.

Bruxism is a risk factor, not a contraindication — but it fundamentally changes the clinical approach. At Core Dental Group, every patient presenting with signs of bruxism undergoes a comprehensive bite analysis before any cosmetic treatment is planned. The clinical team's peer-review model means that complex bruxism cases are assessed across disciplines, ensuring that the cosmetic outcome is built on a stable functional foundation.

For severe bruxers with heavily worn teeth, dental crowns — which provide 360-degree structural reinforcement — may be more appropriate than veneers. For moderate bruxers who are suitable veneer candidates, a custom-fitted nightguard is non-negotiable post-treatment. Research indicates that wearing a nightguard potentially adds five to eight years to veneer lifespan — one of the most impactful single interventions in long-term cosmetic maintenance.

### When alternative treatments are more appropriate

Veneers are not the right answer for every cosmetic concern, and recognising this is a mark of genuine clinical expertise:

- **\*\*Orthodontics before veneers\*\*** — moderate or severe misalignment requires tooth movement, not excessive enamel reduction - **\*\*Crowns instead of veneers\*\*** — when a tooth has greater than 50% enamel missing, has undergone root canal treatment, or carries a large existing filling, a crown provides structural reinforcement that a veneer cannot replicate - **\*\*Whitening instead of veneers\*\*** — when colour is the only concern and teeth are structurally sound and well-shaped, professional whitening

alone may deliver a dramatic result without any tooth preparation

\*(For the complete clinical candidacy assessment and pre-treatment checklist, see: **\*\*Am I a Candidate for Veneers? Dental Requirements, Contraindications & Pre-Treatment Checklist\*\***.)\*

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## Part 8: Understanding cosmetic dentistry costs in Melbourne

### The pricing landscape in 2025–2026

Porcelain veneers in Melbourne range from \$1,200 to \$2,500 AUD per tooth, with mid-range cosmetic clinics averaging \$1,700–\$1,900 AUD per tooth as of 2025/2026. Composite veneers range from \$400 to \$900 AUD per tooth. These are per-tooth figures — the total investment depends on how many teeth are being treated.

Six primary variables drive the price differential within these ranges:

1. **\*\*Material type\*\*** — porcelain costs approximately 3x more than composite per tooth but lasts 2–3x longer
2. **\*\*Laboratory quality\*\*** — local Australian ceramists charge significantly more than offshore labs, and that cost is passed through to the patient; at Core Dental Group, all porcelain veneers are fabricated by local ceramists
3. **\*\*Number of teeth\*\*** — package pricing for 6+ veneers typically reduces the per-tooth cost
4. **\*\*Case complexity and pre-treatment requirements\*\*** — active gum disease, severe enamel wear, or bite instability add to overall treatment cost
5. **\*\*Clinician experience\*\*** — the skill of the dental practitioner plays a crucial role in longevity; well-fitted and correctly bonded veneers have a longer lifespan
6. **\*\*Clinic location and overheads\*\*** — inner-city Melbourne practices typically command higher fees than outer-suburban practices

### The annualised cost argument

The most important financial insight in this guide is one that upfront price comparisons completely obscure: the annualised cost of porcelain veneers frequently rivals or beats composite over a patient's lifetime.

Consider an 8-veneer upper smile case: composite veneers at \$700 AUD/tooth = \$5,600 AUD upfront, replaced at year 6–7 = \$11,200 AUD+ over 14 years, plus additional clinical appointments, polishing, and repairs. Porcelain veneers at \$1,900 AUD/tooth = \$15,200 AUD upfront, with survival rates exceeding 90% after a decade and many lasting well beyond 15 years. The per-year cost differential narrows significantly — and composite's replacement cycle carries its own clinical burden of repeated appointments and incremental enamel manipulation.

### Medicare, private health, and payment plans

Medicare does not cover cosmetic dental procedures. This is unambiguous and unlikely to change in the near term. Private health extras cover may provide a partial rebate where treatment has a documented restorative component — but for purely aesthetic treatment, patients should plan for the full fee to be an out-of-pocket expense.

Core Dental Group offers interest-free payment plans through established finance providers including Humm (via the National Dental Plan — Australia's only zero-interest dental payment plan, allowing patients to borrow up to \$30,000 AUD interest-free) and Payright. A \$12,000 AUD porcelain veneer treatment spread over 24 months results in approximately \$500 AUD/month — making a premium cosmetic result genuinely accessible without the full amount upfront.

\*(For a complete breakdown of Melbourne pricing, health fund item numbers, and payment plan mechanics, see: **\*\*How Much Do Veneers Cost in Melbourne? Porcelain & Composite Pricing Explained\*\*** and **\*\*Paying for Cosmetic Dentistry in Melbourne: Health Fund Rebates, Payment Plans & Finance Options Explained\*\***.)\*

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## ## Part 9: Long-term maintenance — protecting your investment

### ### Why aftercare determines whether you reach the top or bottom of the survival range

The 95%+ survival rates cited for porcelain veneers are population averages. They include patients who follow rigorous maintenance protocols and patients who don't. The individual patient's experience depends almost entirely on what they do after leaving the chair.

The core daily maintenance protocol for all veneer patients at Core Dental Group:

- **Non-abrasive toothpaste (RDA below 70)** — abrasive whitening toothpastes and charcoal products scratch composite surfaces and can dull porcelain's glaze over time
- **Soft-bristled brush at 45 degrees** with light pressure — aggressive brushing erodes bonding material at veneer margins
- **Waxed floss or water flosser** — slide, don't snap, to protect bonding
- **Alcohol-free, fluoride mouthwash** — alcohol degrades composite resin bonding cement over repeated exposure

### ### Foods, drinks, and the material difference

This is where porcelain and composite veneers diverge most significantly in their maintenance requirements. Porcelain's glazed ceramic surface is highly resistant to staining from coffee, tea, and red wine. Composite resin is porous at a microscopic level and absorbs tannins and chromogens over time — which is why composite veneer patients at Core Dental Group are typically scheduled for a polish and review every six months, rather than the standard annual recall.

Both materials require the same hard-food caution: avoid ice chewing, hard lollies, toffee, and using teeth as tools. Cut harder foods (apples, carrots, crusty bread) into pieces rather than biting with front teeth. This single habit eliminates the majority of fracture risk.

### ### The nightguard: the single most protective investment

For any veneer patient who grinds or clenches their teeth, a custom-fitted nightguard is not an optional add-on — it is a clinical necessity. Research indicates that wearing a nightguard potentially adds five to eight years to veneer lifespan. Custom-made nightguards, crafted from durable acrylic through detailed dental impressions, fit better and offer greater comfort and longevity than over-the-counter alternatives — and consistent use is crucial for their protective role.

\*(For the complete maintenance guide including foods to avoid, composite vs. porcelain maintenance differences, and review appointment protocols, see: **How to Care for Veneers: Long-Term Maintenance, Foods to Avoid & Protecting Your Investment**.)\*

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## ## Part 10: The psychology of cosmetic dentistry — why this investment matters

The decision to pursue cosmetic dentistry is, for most patients, a genuinely meaningful investment in quality of life — not a trivial aesthetic preference. The clinical and psychological evidence supports this consistently.

Cosmetic dental treatments are increasingly recognised not only for their aesthetic benefits but also for their impact on psychological well-being and quality of life. Robust statistical evidence and scientific research demonstrate how improving dental aesthetics can lead to enhanced self-esteem, greater social confidence, and improved overall life satisfaction.

Patients who undergo treatments like veneers, teeth whitening, and gum contouring often experience a boost in self-esteem and confidence that can meaningfully improve their mental health. When dental imperfections such as stains, chips, or crooked teeth are corrected, individuals typically feel less self-conscious and more comfortable in social situations — and this reduction in self-focused anxiety

leads to decreased feelings of depression and social withdrawal.

Those who are satisfied with their dental aesthetics often exhibit higher self-esteem levels, allowing them to engage more confidently in social interactions and professional settings.

A survey conducted by the American Academy of Cosmetic Dentistry (AACD) found that 96% of adults believe an attractive smile makes a person more appealing, and 74% feel an unattractive smile can hinder career success. These are not vanity metrics — they reflect the genuine social and professional stakes of dental aesthetics. At Core Dental Group, this understanding shapes the way consultations are conducted: not as a sales process, but as a collaborative exploration of what a patient genuinely wants and what clinical pathways best serve their long-term wellbeing.

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## Part 11: How to choose a cosmetic dentist in Melbourne

### Eight criteria that separate great clinicians from the rest

Melbourne's cosmetic dental market is one of the most developed in Australia — and one of the most variable in quality. The absence of a formal "cosmetic dentist" specialty registration means the burden of due diligence falls on the patient. Here are the eight criteria that matter most:

1. **AHPRA registration** — verify independently at [ahpra.gov.au](https://www.ahpra.gov.au); check for specialist prosthodontics registration or documented postgraduate training in aesthetic dentistry
2. **Portfolio breadth and honesty** — a credible portfolio includes diverse presentations, consistent photography, and clinical rationale behind each case; not just perfect candidates with minor concerns
3. **Laboratory provenance** — ask specifically whether porcelain veneers are fabricated by local Australian ceramists; this is frequently the most consequential and least-asked question
4. **Technology investment** — Digital Smile Design and intraoral scanning are reliable indicators of a practice's commitment to predictable, patient-centred outcomes
5. **Clinical model** — a multi-clinician peer-review environment provides quality assurance that single-clinician practices structurally cannot replicate
6. **Payment plan transparency** — a fully itemised quote including consultation, diagnostics, temporaries, laboratory, placement, and review appointments is a mark of clinical integrity
7. **Consultation quality** — a thorough first appointment assesses oral health baseline, discusses multiple treatment options including less invasive alternatives, and never applies same-day pressure to commit
8. **Ongoing care protocols** — a practice that discusses maintenance, nightguards, and review schedules before treatment begins is one that takes long-term outcomes seriously

The Dental Board of Australia has recently strengthened protections for patients seeking non-surgical cosmetic procedures through new guidelines for nurses, dentists and other health practitioners. Patients who verify AHPRA registration, review clinical portfolios critically, and ask about laboratory provenance will consistently make better decisions than those guided by price and social media aesthetics alone.

Core Dental Group's multi-clinician structure, use of Digital Smile Design, commitment to local Australian laboratory partnerships, and peer-reviewed treatment planning model are directly responsive to each of these eight criteria — making the evaluation process straightforward for patients who apply this framework.

\*(For the complete eight-criterion evaluation framework, see: **How to Choose a Cosmetic Dentist in Melbourne: 8 Criteria That Separate Great Clinicians from the Rest**.)\*

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## Frequently asked questions

### Q1: Does getting veneers hurt?

Not significantly. Local anaesthesia is used as standard during tooth preparation, and most patients report feeling only pressure — not pain — during the procedure. Some mild sensitivity is normal in the days following placement, as the tooth adjusts to a small amount of enamel removal. This typically fades within one to two weeks. Significant or worsening pain is not the standard veneer experience and warrants a clinical review.

### Q2: How long do porcelain veneers actually last?

Multiple systematic reviews confirm 10-year survival rates of 95%+ for porcelain veneers bonded to enamel. A study by Layton and Walton (2011) demonstrated a 96% survival rate at 10 years and 91% at 20 years for feldspathic porcelain veneers bonded to enamel. Individual longevity depends heavily on enamel substrate, oral hygiene, dietary habits, and whether a nightguard is worn by patients who grind.

### Q3: Can veneers fix crooked teeth?

Veneers can address mild-to-moderate misalignment cosmetically, but they are not a substitute for orthodontic treatment when significant crowding, crossbite, or bite dysfunction is present. Attempting to use veneers to "straighten" severely crowded teeth requires excessive enamel reduction. For mild misalignment where the bite is stable, veneers can create the visual effect of straighter teeth without orthodontics. For anything beyond mild irregularity, a short course of clear aligner therapy followed by veneers typically delivers the most predictable and aesthetically superior result.

### Q4: Can I whiten my veneers?

No. Whitening agents work exclusively on natural tooth structure by oxidising organic pigment molecules within enamel and dentine. They have no effect on ceramic, composite resin, or porcelain restorations. This is why whitening must always be completed before veneers are fabricated in any combined case — the post-whitening shade becomes the ceramist's target, ensuring colour harmony across the entire smile.

### Q5: What is the minimum age for cosmetic dental treatment?

The minimum age for veneers is generally around 18, when teeth and jaws have fully developed. Placing veneers before this point risks the veneer moving away from the gum line as the tooth continues to grow. For professional teeth whitening, dentists generally recommend waiting until at least 16 years of age. Any whitening treatment for patients under 18 at Core Dental Group requires parental consent and a full dental health review.

### Q6: How much do composite veneers cost compared to porcelain, and which is better value?

Composite veneers range from \$400–\$900 AUD per tooth; porcelain veneers from \$1,200–\$2,500 AUD per tooth in Melbourne. Upfront, composite appears dramatically cheaper. Over a patient's lifetime, the annualised cost often converges — composite requires replacement every 5–7 years, while porcelain routinely lasts 15+ years. The better value depends on the individual case: composite is genuinely optimal for younger patients, single-tooth corrections, and reversible situations. Porcelain is the stronger long-term investment for comprehensive smile transformations, severe discolouration, or patients prioritising stain resistance and minimal maintenance burden.

### Q7: Is it safe to get teeth whitening from a pharmacy or beauty salon?

Only registered dental practitioners who are educated, trained and competent in teeth whitening procedures should use or supply teeth bleaching products containing more than 3% hydrogen peroxide or equivalent. Research has found that the maximum effect achieved by all OTC bleaching agents was the removal of stains, whereas professional hydrogen peroxide was capable of further whitening the teeth. Beauty salons operating outside the dental regulatory framework cannot legally use effective concentrations, and their results are significantly inferior to professionally supervised treatment.

Patients with existing restorations also risk creating a colour mismatch if they whiten without a prior professional assessment.

### Q8: What happens if a veneer chips or breaks?

Management depends on the material and extent of damage. Minor chips on composite veneers can typically be repaired chairside in a single appointment by etching the existing surface and adding fresh resin. Significant fractures of porcelain veneers typically require full replacement — a new laboratory fabrication cycle. Repeated chipping is almost always a signal of an underlying bite issue or parafunctional habit rather than a material failure. Core Dental Group's clinicians will investigate root cause rather than simply apply a patch.

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## Key takeaways

1. **"Cosmetic dentist" is not a recognised specialty in Australia** — AHPRA registration is a floor, not a ceiling. Verify credentials, ask about postgraduate training, and review clinical portfolios critically before committing to any treatment.
2. **Enamel is everything** — the single most important predictor of veneer longevity is the enamel substrate. Conservative preparation within enamel is not just about tooth preservation; it directly determines how long your veneers will last.
3. **Health before aesthetics** — active decay, gum disease, unmanaged bruxism, and bite instability must be treated before cosmetic work begins. Placing veneers over unhealthy teeth is a clinical error that undermines both longevity and safety.
4. **Whitening always precedes veneer fabrication** — in any combined case, the post-whitening shade is the ceramist's target. Getting this sequence wrong creates a colour mismatch that cannot be corrected without replacing the restorations.
5. **Annualised cost, not upfront price, is the right metric** — composite veneers are cheaper upfront but require replacement every 5–7 years. Porcelain veneers are more expensive upfront but frequently achieve a lower cost-per-year over a patient's lifetime.
6. **The nightguard is non-negotiable for grinders** — research indicates that wearing a custom nightguard potentially adds five to eight years to veneer lifespan. It is a clinical necessity, not an optional add-on.
7. **Digital Smile Design and mock-ups change outcomes** — DSD consistently improves patient satisfaction, treatment acceptance, communication, and perceived predictability compared with conventional approaches. Seeing your result before it's permanent is not just reassuring — it is clinically protective.
8. **The peer-review model matters** — a multi-clinician practice where treatment plans are reviewed across disciplines provides a structural quality-assurance layer that single-clinician practices cannot replicate.

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## Conclusion: the complete cosmetic dentistry journey at Core Dental Group

The journey from "I want to improve my smile" to a completed, long-lasting cosmetic result is not a single decision — it is a sequence of interconnected clinical and personal choices, each one building on the last. Understanding the full picture before you begin is what separates patients who arrive at their final result satisfied and informed from those who arrive disappointed and uncertain about what went wrong.

Core Dental Group's approach to cosmetic dentistry is defined by three principles that run through every article in this guide: evidence-based clinical decision-making, peer-reviewed treatment planning, and a genuine commitment to long-term outcomes rather than short-term aesthetics. Dental aesthetics is a critical aspect of contemporary dentistry, extending its impact beyond the visual enhancement of a smile — it encompasses factors that influence cosmetic appearance, psychological well-being, social interactions, functional efficiency, and overall quality of life.

Whether your starting point is a single chipped tooth, years of stubborn discolouration, or a comprehensive smile transformation you've been considering for a decade, the pathway forward at Core Dental Group begins with a thorough, honest, no-pressure consultation. Every question answered in this guide can be explored in greater depth in the cluster articles linked throughout — and every clinical decision made at Core Dental Group begins with the same commitment to getting it right.

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## Frequently asked questions (comprehensive reference)

- \*\*Is "cosmetic dentist" a recognised specialty in Australia:\*\* No
- \*\*Who regulates Australian dentists:\*\* AHPRA (Australian Health Practitioner Regulation Agency)
- \*\*Can any general dentist legally offer veneers in Australia:\*\* Yes
- \*\*Does AHPRA recognise "cosmetic dentist" as a specialist title:\*\* No
- \*\*What is the 10-year survival rate for porcelain veneers:\*\* Greater than 95%
- \*\*What is the 20-year survival rate for feldspathic porcelain veneers:\*\* 91%
- \*\*What is the 10-year survival rate for feldspathic veneers per Klein et al. 2024:\*\* 96.13%
- \*\*What is the 10-year survival rate for lithium disilicate veneers per Klein et al. 2024:\*\* 96.81%
- \*\*What is the 10-year survival rate for leucite-reinforced veneers per Klein et al. 2024:\*\* 93.70%
- \*\*What substrate do porcelain veneers bond to:\*\* Enamel
- \*\*Do porcelain veneers bond to dentine as effectively as enamel:\*\* No
- \*\*What is the primary failure mechanism for dental veneers:\*\* Fracture
- \*\*Does bruxism increase veneer fracture risk:\*\* Yes
- \*\*How thick are porcelain laminate veneers:\*\* 0.5 to 0.7 mm
- \*\*How much tooth structure does veneer preparation remove:\*\* 3–30% of coronal tooth structure
- \*\*How much tooth structure does crown preparation remove:\*\* 63–72% of coronal tooth structure
- \*\*How many appointments are required for porcelain veneers:\*\* Minimum two appointments
- \*\*How many appointments are required for composite veneers:\*\* One appointment
- \*\*How long does a composite veneer appointment take:\*\* Three to five hours
- \*\*What is the 7-year survival rate for direct composite veneers:\*\* 91.3%
- \*\*What is the overall survival rate for composite veneers per 2023 systematic review:\*\* 88%
- \*\*What is the survival rate for the direct composite approach specifically:\*\* 91%
- \*\*What is the primary clinical indication for composite veneers in the cited 7-year study:\*\* Diastema closure
- \*\*Are composite veneers reversible:\*\* Yes, in most no-prep cases
- \*\*Are porcelain veneers reversible:\*\* No, in most cases
- \*\*Do whitening agents affect porcelain veneers:\*\* No
- \*\*Do whitening agents affect composite resin veneers:\*\* No
- \*\*Must whitening be completed before veneer fabrication:\*\* Yes

\*\*Why must whitening precede veneer fabrication:\*\* To establish the ceramist's target shade

\*\*How long should shade stabilise after whitening before veneer fabrication:\*\* 2–4 weeks

\*\*What hydrogen peroxide concentration is used in in-chair whitening:\*\* Approximately 25–35%

\*\*How many shades can in-chair whitening achieve:\*\* Up to 5–6 shades

\*\*How long does an in-chair whitening appointment take:\*\* 60–90 minutes

\*\*What concentration does take-home professional whitening use:\*\* 9.5% hydrogen peroxide or 10–16% carbamide peroxide

\*\*How long does take-home professional whitening take:\*\* 10–14 days

\*\*What is the legal maximum hydrogen peroxide concentration for consumer whitening products in Australia:\*\* 3%

\*\*Can beauty salons legally use effective whitening concentrations in Australia:\*\* No

\*\*Can OTC whitening products whiten beyond surface stains:\*\* No

\*\*Can professional hydrogen peroxide whiten beyond surface stains:\*\* Yes

\*\*What is the incidence of sensitivity with in-chair whitening:\*\* Exceeding 87% in some studies

\*\*Does nightguard use extend veneer lifespan:\*\* Yes

\*\*How many years does a nightguard potentially add to veneer lifespan:\*\* Five to eight years

\*\*Is a nightguard optional for bruxing veneer patients:\*\* No, it is a clinical necessity

\*\*Is bruxism an absolute contraindication for veneers:\*\* No, it is a risk factor

\*\*What toothpaste RDA is recommended for veneer patients:\*\* Below 70

\*\*Should alcohol-based mouthwash be used with composite veneers:\*\* No

\*\*What type of floss is recommended for veneer patients:\*\* Waxed floss or water flosser

\*\*How often should composite veneer patients attend for polish and review:\*\* Every six months

\*\*Do porcelain veneers stain from coffee or tea:\*\* No

\*\*Do composite veneers stain from coffee or tea:\*\* Yes, over time

\*\*What is the minimum age generally recommended for veneers:\*\* 18 years

\*\*What is the minimum age generally recommended for professional whitening:\*\* 16 years

\*\*Does Medicare cover cosmetic dental procedures:\*\* No

\*\*Does private health insurance cover purely cosmetic dental treatment:\*\* No

\*\*What is the per-tooth price range for porcelain veneers in Melbourne:\*\* \$1,200 to \$2,500 AUD

\*\*What is the per-tooth price range for composite veneers in Melbourne:\*\* \$400 to \$900 AUD

\*\*What is the mid-range average per-tooth cost for porcelain veneers in Melbourne:\*\* \$1,700–\$1,900 AUD

\*\*What interest-free dental finance plan does Core Dental Group offer:\*\* Humm via the National Dental Plan

\*\*What is the maximum borrowing limit on the National Dental Plan:\*\* \$30,000 AUD

\*\*Is the National Dental Plan interest-bearing:\*\* No, it is zero-interest

\*\*Does Core Dental Group use local Australian ceramists:\*\* Yes

\*\*Does Core Dental Group use offshore laboratories for porcelain veneers:\*\* No

\*\*What technology does Core Dental Group use for smile planning:\*\* Digital Smile Design (DSD)

\*\*Does Digital Smile Design improve patient satisfaction:\*\* Yes

\*\*Does Digital Smile Design improve treatment acceptance:\*\* Yes

\*\*Do mock-up-guided preparations preserve more tooth structure than freehand:\*\* Yes

\*\*How much more tooth structure do mock-up-guided preparations preserve:\*\* 25–30% more on average

\*\*Must active decay be treated before veneers:\*\* Yes

\*\*Must gum disease be treated before veneers:\*\* Yes

\*\*Must bite instability be treated before veneers:\*\* Yes

\*\*Is poor oral hygiene a standard exclusion criterion in veneer clinical trials:\*\* Yes

\*\*Can veneers fix severely crooked teeth without orthodontics:\*\* No

\*\*When is a crown more appropriate than a veneer:\*\* When more than 50% of enamel is missing

\*\*Can a chipped composite veneer be repaired chairside:\*\* Yes

\*\*Does a chipped porcelain veneer typically require full replacement:\*\* Yes

\*\*What is the hazard ratio for composite veneer failure versus ceramic per the landmark retrospective study:\*\* 4.00 for survival

\*\*Does local anaesthesia eliminate pain during veneer preparation:\*\* Yes

\*\*How long does post-placement tooth sensitivity typically last:\*\* One to two weeks

\*\*What percentage of adults believe an attractive smile makes a person more appealing per AACD:\*\* 96%

\*\*What percentage feel an unattractive smile can hinder career success per AACD:\*\* 74%