

CONSENT TO DENTAL TREATMENT

Patient: _____

Date: _____

Time: _____ (A.M.) (P.M.)

I hereby authorize Dr. _____ and his/her associates at _____
_____ to perform upon me or the named patient the following
procedures(s): _____
_____ (Explain in plain English).

Dr. _____ has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedure(s) which the above-named dentist or his/her associates may consider necessary.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

I hereby consent to the proposed dental treatment.

Signature of Patient or Guardian

Date

Interpreter (If used)

Date

Signature of Witness

Date

Dentist Certification:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and attendant risks), to the proposed procedures. I have offered answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

Dentist's Signature _____

Print Name _____ Date _____

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