

PATIENT NUMBER

PATIENT'S NAME \_\_\_\_\_  
Last First Initial Date of Birth

After an examination, the dentist has explained that my dental conditions:

The dentist has recommended the following treatment:

The dentist has advised me of the following risks and consequences of the treatment:

The dentist has advised me of the risks and consequences should I choose not to have this treatment done:

The dentist has advised me of the following alternative treatments:

The dentist has advised me of the following risks, advantages and disadvantages of these alternative treatments:

I hereby authorize \_\_\_\_\_

Doctor's Name

and whomever he/she may designate as his/her assistants, to perform the following treatment or procedure:

I realize that in spite of the possible complications and risks, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this treatment or procedure.

I am allergic to the following antibiotics, drugs, medications and foods:

I have provided as accurate and complete a medical and personal history as possible and will follow all instructions as explained to me and directed.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, and the risks and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

\_\_\_\_\_  
Patient or Guardian's Signature Date

I personally have explained the above information to the patient or the patient's guardian.

\_\_\_\_\_  
Dentist's Signature Date

\_\_\_\_\_  
Witness's Signature Date

# CONSENT TO DENTAL TREATMENT