

## CONSENT FOR DENTAL TREATMENT

I, (print name) \_\_\_\_\_ have been informed by

Dr. (print name) \_\_\_\_\_, of the need to undergo dental

treatment as presented to me on \_\_\_\_\_.

I have been fully informed about the details of the recommended treatment and alternatives, and agree to accept the treatment as recommended by the doctor.

I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, and reporting to the office any change in my health status as soon as possible.

I have discussed all of the above with the doctor, and all my questions have been answered.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanation, the discussion, and the answers to my questions, I authorize the doctor to complete the treatment as described.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
If a Minor, Signature of Parent Or Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date