

Date: _____

Patient: _____

Date of Birth: _____

I hereby authorize Dr. _____ and his/her associates to perform the following procedure(s);

Dr. _____ has fully explained the benefits, risks, and prognosis of the proposed treatment including possible complications, as well as not getting the proposed treatment:

Dr. _____ also discussed other treatment options and alternatives:

I understand that during the course of treatment, unforeseen conditions may arise and may necessitate further procedures and / or deviation from the initial treatment plan, therefore I consent to the performance of additional procedures that Dr. _____ consider necessary to complete the treatment plan for my benefit.

I understand that due to the nature of any dental treatment, there are no guarantees/warranties.

All of my questions have been answered to my satisfaction.

I understand my financial obligations, and that I am responsible for all fees regardless of insurance coverage, unless prior arrangements have been made.

I confirm that I have read and understand the above. I hereby consent to the proposed treatment plan.

Patient/Legal Guardian Name: _____

Patient/Legal Guardian Signature: _____

Interpreter (if needed): _____

Witness: _____

Dentist Certification:

I certify that I have explained the above proposed treatment including risks, benefits, alternative treatment options, as well as the consequences of no treatment. I have answered all the patient's questions to her/his satisfaction and believe that the patient fully understands what I have explained.

Dentist: _____

Date: _____

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