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ARTISTRY • INTEGRITY • PASSION

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## **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	
<ul> <li>I have been fully informed about the details of the recomm treatment as recommended by the doctor.</li> </ul>	nended treatment and alternatives, and agree to accept the
<ul> <li>I understand that as the treatment proceeds there may be informed before any change is instituted.</li> </ul>	need to change the treatment plan. If this occurs I expect to be
<ul> <li>I further understand that individual reactions to treatment reactions during or following any treatment, I agree to report</li> </ul>	cannot be predicted, and that if I experience any unanticipated ort them to the office as soon as possible.
	atment depends upon my cooperation in keeping scheduled oral hygiene and dietary instructions, and reporting to the office
<ul> <li>I have discussed all of the above with the doctor, and all my</li> </ul>	y questions have been answered.
<ul> <li>I acknowledge that no guarantees or assurances have been</li> </ul>	given by anyone as to the results that may be obtained.
<ul> <li>Following the explanation, the discussion, and the answers treatment as described.</li> </ul>	to my questions, I authorize the doctor to complete the
Patient's Signature	If a Minor, Parent/Guardian Signature
Witness Signature	Doctor's Signature
Date	

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