PATIENT CONSENT FORM

Patient:_______________________________________ Date:____________________

I voluntarily request Dr. ______________and such technical assistants appointed by the doctor to treat my condition(s) which have been explained to me as:

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I understand that to treat my condition(s), the following procedures are planned for me, and I voluntarily consent and authorize the following:

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I understand that no warranty or guarantee has been made to me as the result or cure. Just as there may be many hazards in continuing my present condition without treatment, there are also risks and hazards related to the planned procedure(s). I realize that risks or complications may ultimately develop and/or occur related to the following initialed procedures. These may include but are not limited to the following:

1. ______ Local anesthetic - bruising, tenderness, prolonged numbness, or allergic reaction.

2. ______ Fillings – sensitivity, tissue irritation, nerve exposure.

3. ______ Crowns/Bridges – temperature sensitivity, tissue irritation, nerve exposure, further decay, tooth fracture, porcelain fracture, inadequate blend to other teeth, or even loss of tooth.

4. ______ Root Canals – infection, fracture, separation of instrument, perforation of tooth, incomplete seal, loss of tooth. I understand that the performance of the procedure in no way guarantees that the tooth will not require further treatment or even removal in the future.

5. ______ Soft Tissue Management (Gum Therapy) – soreness, temperature sensitivity. I understand that the performance of this procedure in no way guarantees that antibiotic therapy, gum surgery, or further treatment, including extraction, may not be needed in the future.

6. ______ Partials/Dentures – soreness, tissue changes, changes in appearance and/or bite, imperfect shade blend.

7. ______ Implant Restorations – soreness, tissue changes, imperfect shade blend, changes in appearance and/or bite, failure of implant.

8. ______ Splint Therapy – muscle tenderness, bite changes. I understand that this appliance in no way guarantees to correct or alleviate symptoms. I understand that further measures or restorations may be needed.

9. ______ Whitening – temperature sensitivity, tissue irritation, lack of significant color change.

10. Other____

______ I have been given the opportunity to ask questions about my condition(s), alternative forms of treatment, risks of treatment, the procedure(s) to be done, and the risks of hazards involved, and I believe that I have sufficient information to give this informed consent.

______ I certify that this form has been fully explained to me, that I have read or had it read to me, that all blanks have been filled in. I understand its contents, and I consent to proceed with treatment recommended.
****In case the patient is a minor, the "I" refers to the parent or guardian.**

______________________________ ________________________ _____
Responsible party Date Witness Date Doctor Initials

Update

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