

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below.

Patient Name _____

Date _____

WORK TO BE DONE Initial _____

I understand that I am having the following treatment and have been informed of the consequences of both having and not having the treatment done:

Restoration(fill,crn,brg)___ Cleaning(FMD,SRP,Prophy)___ Root Canal ___ Extraction ___ Other ___

CHANGES IN TREATMENTS PLAN Initial _____

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary and understand there may be additional costs involved.

DRUGS AND MEDICATIONS Initial _____

I understand that I may be given antibiotics, analgesics and other medications and these can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction), etc.

DAILY MEDICATIONS Initial _____

I am aware that I consume certain medications which may cause a variety of health problems while getting such dental treatment done, I made the dentist aware of all the medications I am taking and I understand the risks. I am willingly allowing the dentist to provide my dental treatment and I am, myself, liable for any major health occurrences.

Patient Signature _____

Date _____

Parent/Guardian _____

Date _____

Dentist Signature _____

Date _____

Witness Signature _____

Date _____