



Consent to Dental Treatment Template

This sample form is for illustrative purposes only. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.

Informed Consent for Dental Treatment

Patient Name: _____ Date of Birth: _____

I hereby give consent to Dr. _____ to perform _____
("Treatment/Procedure") on me or my dependent by _____
("Recommended Treatment/ Procedure") and any such additional treatment/procedure(s) as
may be considered necessary for my well-being based on findings made during the course of
the Recommended Treatment. The nature and purpose of the Recommended
Treatment/Procedure have been explained to me and no guarantee has been made or implied
as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to
proceed with the Recommended Treatment/Procedure.

Name of Person who Explained Treatment/Procedure

Signature

1. I understand that the above-described treatment or procedure involves the following risks:
Numbness Pain Swelling Root Canal Therapy Fracture
2. I understand that the above-described treatment or procedure involves the following benefits:
3. As an alternate to this therapy, I may elect:
No treatment or Alternative materials:

4. I also understand that failure to treat this condition will result in:
Possible/complete fracture Leakage (micro) Possible Tooth Loss Infection
5. Further, it is understood that unforeseen conditions or circumstances may arise during the course of the above-described procedure or alternate treatment. Therefore, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist believes necessary or advisable as a result of these unforeseen events or conditions.

6. I consent to the administration of any anesthetic that the dentist (or his appointees) deems necessary to provide proper treatment.
7. I understand that there are risks involved with the administration of anesthesia. The alternative to the use of these anesthetics is: No anesthetic, Sedation, or Nitrous Oxide
8. I have been given an opportunity to refuse to consent to any and all treatment or procedures specified in this form and have indicated my exclusions by drawing a line through the objectionable word(s), sentence(s), or paragraph(s), and writing my initials next to the portion to which I refuse to consent. I am also free to indicate at the end of this form anything not mentioned herein, but to which I refuse to consent.

I certify that I have read and understand the above. I accept all risk of, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about this treatment plan and its attendant risks have been answered fully and to my complete satisfaction.

I have been given the opportunity to discuss financial arrangements. I agree to pay the estimated in-network patient responsibility today. I agree to pay in full if not utilizing insurance, if my insurance is out of network, or if a procedure is a non-covered benefit. _____

Initial

Signature (Patient/Parent/Guardian)

Date/Time

Relationship (if patient is a minor)

Witness

Date/Time