Dental Procedure Informed Consent Form

Please read this document carefully. This form is designed to provide you with information regarding your proposed dental treatment so that you may make an informed decision to give or withhold consent.

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1. Patient Information

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

2. Proposed Treatment & Procedures

The following dental procedure(s) have been recommended for your treatment plan:

Recommended Procedure(s): _____

Tooth / Teeth Number(s): _____

Estimated Number of Visits: _____

3. Information Regarding Risks and Alternatives

As with all dental and medical procedures, there are certain risks involved. These may include, but are not limited to:

- Pain, swelling, or bruising after the procedure.
- Infection or bleeding at the site of treatment.
- Temporary or permanent numbness of the lip, tongue, chin, or gums.
- Damage to adjacent teeth, fillings, or soft tissue.
- Reaction to local anesthetics or other medications.
- Failure of the treatment requiring additional procedures or extraction.

Alternative treatment options (including no treatment) have been discussed, along with their respective risks and benefits.

4. Patient Consent & Acknowledgement

By signing below, I acknowledge and agree to the following statements:

- I have read this form, or it has been read to me, and I fully understand the proposed treatment.
- I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.
- I understand the risks, benefits, and alternatives to the recommended treatment.
- I understand that no guarantee or assurance has been given as to the results that may be obtained.
- I voluntarily consent to the dental procedures listed above to be performed by the dentist and authorized clinical staff.

5. Signatures

Please print this form and sign below in ink.

Printed Patient/Guardian Name: _____

Relationship to Patient (if Guardian): _____

Patient/Guardian Signature: _____

Date Signed (MM/DD/YYYY): _____

Printed Dentist Name: _____

Dentist Signature: _____

Date Signed (MM/DD/YYYY): _____

Printed Witness Name:

Witness Signature: _____

Date Signed (MM/DD/YYYY):