

**Consent for Treatment**

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) listed in my treatment plan. I understand my dental condition and have discussed any available alternate treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details.

I understand the risks inherent in the treatment(s). I have discussed these risk with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures, I understand that withholding this information maybe affect the outcome of the procedure(s) or course(s) of treatment.

I give my consent for the undersigned provider and any other qualified assistant or medical professionals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedure to be performed in the event of an emergency during the procedure(s) or course(s) of treatment.

I confirm that I understand this form and the information contained therein. I am fluent in English or have been offered the opportunity to discuss treatment in my native language.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_