Dental Treatment Consent Form

Patient information	
Full name: Gregory Wilson	Date of birth: March 28, 1991
Age: 33	Contact number: XXX-XXX-XX
Address: 3 Elm Street, Apt 4B, Springfield, IL, 62701	
Legal guardian information	
Parent/legal guardian’s name:	
Relationship to patient:	Age:
Contact number:	
Treatment details	
Proposed treatment/s:	
Dental cleaning Cavity filling for tooth #14 Fluoride treatment	
Dentist performing the treatment: Lisa Cuddy, DDS	
Date: August 12, 2024	
Description of proposed treatments	
The dental procedure(s) may include (but is/are not limited to):	
Removal of plaque and tartar Filling of cavities Application of fluoride to protect teeth	

The nature of the treatment, expected benefits, potential risks, and alternatives to the procedure(s) have been explained to me.

I, Gregory Wilson, understand that during the course of treatment, unforeseen conditions may be revealed that may require different procedures or additional treatments.

Risks and complication

I, Gregory Wilson, acknowledge that the following risks are associated with the proposed treatment(s):

- Pain, discomfort, or swelling
- Possible infection
- Prolonged numbness or altered sensation
- Damage to surrounding teeth or tissues
- Need for further treatments, adjustments, or procedures
- Others: Allergic reaction to materials

Anesthesia/medications

I, Gregory Wilson, consent to the use of anesthesia or medication as necessary for the dental treatment. I understand that the administration of anesthesia involves risks, including allergic reactions or complications.

Anesthesia to be administered: ○ Local ◉ General ○ Nitrous Oxide ○ None

Alternative treatments

The dentist has discussed alternatives to the proposed treatment, including:

Delaying the cavity filling
Tooth extraction as an alternative for severely damaged teeth

Post-treatment care

I, Gregory Wilson, understand the importance of following post-treatment instructions provided by the dentist to ensure the success of the treatment and minimize the risk of complications. Failure to do so may affect the outcome of the treatment.

Fees

I, Gregory Wilson, understand that I am responsible for all fees associated with the proposed treatment. I acknowledge that I have been informed of the estimated costs and that payment is expected according to the office's financial policy.

Consent statement

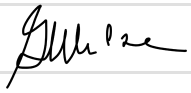
For legal guardian only

As the parent or legal guardian of the patient, I, [Legal guardian's name], confirm the following:

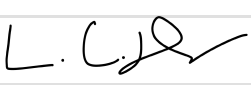
- I have the legal authority to consent to this treatment.
- I have reviewed the proposed treatment, potential risks, and alternatives, and I give my informed consent on behalf of the patient.

For patient/legal guardian

I, Gregory Wilson, have had the opportunity to ask questions about the treatment and fully understand the nature, risks, and alternatives to the proposed procedures. By signing below, I give my informed consent to the treatment.

Patient or legal guardian's signature: 

Date: August 12, 2024

Dentist's signature: 

Date: August 12, 2024