Dental Treatment Consent Form

Patient information	
Full name:	Date of birth:
Age:	Contact number:
Address:	
Legal guardian information	
Parent/legal guardian’s name:	
Relationship to patient:	Age:
Contact number:	
Treatment details	
Proposed treatment/s:	
Dentist performing the treatment:	
Date:	
Description of proposed treatments	
The dental procedure(s) may include (but is/are not limited to):	
The nature of the treatment, expected benefits, potential risks, and alternatives to the procedure(s) have been explained to me. I, ____[Patient’s name or Legal guardian’s name]____, understand that during the course of treatment, unforeseen conditions may be revealed that may require different procedures or additional treatments.	
Risks and complication	
I, ____[Patient’s name or Legal guardian’s name]____, 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: _____	

Anesthesia/medications

I, _____, 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:

Post-treatment care

I, ____[Patient's name or Legal guardian's name]____, 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, ____[Patient's name or Legal guardian's name]____, 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, ____[Patient's name or Legal guardian's name]____, 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:

Dentist's signature:

Date: