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# DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign section at the bottom of form.

**REASON FOR TODAY'S VISIT**_____

Patient name_____

**WORK TO BE** DONE

I understand that I am having the following work done: fillings__ bridges__crowns__ Extractions__Impacted teeth removed__ general Anesthesia__ Root Canals_____ other___

(Initials_____)

**DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, and/or anaphylactic shock (several allergic reactions.)

(Initials_____)

**CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by any one regarding the dental treatment which I have requested and authorize. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient_____ Date_____

Signature of parent/guardian_____ Date_____