PERMISSION FOR DENTAL PROCEDURES(S)

1. I hereby authorize Dr. _____and his/her associates at _____
_____to perform upon me or the named patient the following procedure(s):
_____
_____(Explain in plain English).

2. Dr. _____ has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

3. I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedures(s) which the above-named dentist or his/her associates may consider necessary.

4. I acknowledge that no guarantees or assurances have been made to me concerning the results intended form the procedure(s).

5. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

Patient/Relative or Guardian*:

_____ _____ _____
Signature Print Name Date

Relationship (if signed by person other than patient): _____

Interpreter (if used):

_____ _____ _____
Signature Print Name Date

Witness:

_____ _____ _____
Signature Print Name Date

* The signature of the patient must be obtained unless the patient is an unemancipated minor (under the age of 10) or is otherwise incompetent to sign.

Dentist Certification:
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____ _____
Dentist's Signature Print Name Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD