DENTAL CONSENT FORM

Patient Information
Name: ______________________
Date of Birth: _______________
Phone Number: _______________
Address: ____________________

Procedure Information
Procedure: ___________________
Date of Procedure: ____________
Dentist Name: ________________

I, the undersigned patient (or guardian of the patient), acknowledge that my dentist has explained the proposed dental procedure, including the risks, benefits, and alternatives, and I consent to the following treatment:

1. Description of the Procedure
The procedure involves:

- Local anesthesia administration for pain management.
- Tooth extraction and/or necessary surgical procedures.
- Possible bone reshaping, sutures, and post-operative care.

2. Risks & Possible Complications
I understand that there are potential risks involved in this procedure, including but not limited to:

- Pain, swelling, and discomfort.
- Bleeding or prolonged healing.
- Infection requiring additional treatment.
- Damage to adjacent teeth or restorations.
- Temporary or permanent numbness of lips, tongue, or face.
- Dry socket (loss of blood clot in the extraction site).
- Jaw joint pain or limited mouth opening.
- Need for additional procedures or referral to a specialist.

3. Alternatives to Treatment
I have been informed of alternative treatments, which may include:

- Root canal therapy.
- Other restorative procedures.

- No treatment (with understanding of potential consequences).

4. Anesthesia Options

I have been informed about the type of anesthesia to be used:

- Local Anesthesia (numbing only).
- Sedation (if applicable).
  I understand that additional risks may be associated with anesthesia and sedation.

5. Patient Responsibilities & Aftercare

I agree to follow all post-procedure care instructions provided by my dentist, including:

- Avoiding smoking, alcohol, and strenuous activities.
- Taking prescribed medications as directed.
- Keeping follow-up appointments.

6. Consent & Acknowledgment

I acknowledge that:

- All my questions have been answered to my satisfaction.
- No guarantees or assurances have been made regarding the outcome.
- I am responsible for the financial cost of the procedure.

By signing below, I voluntarily consent to the treatment as explained to me.

Patient (or Guardian) Signature: ______________________
Date: ____________

Dentist Signature: ______________________
Date: ____________

Witness (if applicable): ______________________
Date: ____________