Medical Treatment Consent for Dental Procedures

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Address: _____

To Whom It May Concern,

I, the undersigned, hereby give my consent for the following dental procedures to be performed on me:

- Procedure 1: _____
- Procedure 2: _____
- Procedure 3: _____

I have been informed about the nature of the proposed treatment, including risks, benefits, and alternatives. I understand that complications may occur but trust my dental care provider to manage any issues that may arise during the procedure.

I acknowledge that I have had the opportunity to ask questions and that my questions have been answered to my satisfaction.

Signature of Patient: _____

Date: _____

Guardian Signature (if applicable): _____

Date: _____

Dentist Name: _____

Practice Name: _____

Contact Information:

Phone: _____

Email: _____