Dental Treatment Consent for Emergency Dental Care

Date: _____

Patient Name: _____

Patient Address: _____

Email: _____

Phone Number: _____

Emergency Contact Information

Name: _____

Phone Number: _____

Consent Statement

I, the undersigned, authorize Dr. _____ and the staff at _____ Dental Office to perform emergency dental treatment as deemed necessary. I understand that this may include diagnostic and therapeutic procedures related to my dental condition.

Risks and Benefits

I acknowledge that I have been informed of the potential risks and benefits of the proposed treatment. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

Financial Responsibility

I understand that I am financially responsible for all services rendered, and that my insurance may not cover all aspects of the treatment.

Signature

Patient Signature: _____

Date: _____

Guardian Signature (if applicable): _____

Date: _____