Dental Treatment Consent Form

Date: **[Insert Date]**

Patient Name: **[Insert Patient Name]**

Patient Address: **[Insert Patient Address]**

Patient Phone Number: **[Insert Patient Phone Number]**

Procedure Details

I, **[Insert Patient Name]**, authorize Dr. **[Insert Dentist Name]** and his/her staff to perform the following routine dental procedures:

- Dental examination
- Dental cleaning (prophylaxis)
- X-rays (if necessary)
- Application of fluoride treatment

Informed Consent

I understand that the purpose of these procedures is to maintain my oral health, prevent dental diseases, and ensure any existing issues are addressed. I have been informed about the nature of the procedures, potential risks, benefits, and alternatives.

I have also been assured that all my questions regarding these procedures have been answered to my satisfaction.

Patient Declaration

By signing below, I consent to the dental treatments as outlined above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Contact Information

If you have any questions or concerns about the procedures, please contact our office at **[Insert Dental Office Phone Number]**.