Dental Treatment Consent Form for Sedation Dentistry

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Procedure Details

I, the undersigned, Consent to the administration of sedation dentistry for the purpose of undergoing the following procedure(s):

- _____
- _____

Risks and Benefits

I understand that sedation dentistry has certain risks and benefits which have been explained to me, including:

- Potential risks: _____
- Potential benefits: _____

Patient Acknowledgment

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

Consent

By signing below, I hereby consent to the sedation dentistry procedure and acknowledge that I have read and understood the information provided above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____