Dental Treatment Consent Form

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Address: _____

Phone Number: _____

Procedure Information

I, the undersigned, give my consent for the following dental surgical procedure(s):

1. Procedure Name: _____
2. Description of Procedure: _____
3. Date of Procedure: _____

Potential Risks

I acknowledge that the dentist has explained the potential risks and complications associated with the procedure, which may include:

- Infection
- Bleeding
- Pain and swelling
- Damage to surrounding teeth or nerves

Patient Acknowledgment

I confirm that I have had the opportunity to ask questions about the procedure, and all my questions have been answered to my satisfaction. I understand the nature of the procedure being performed and the associated risks.

By signing below, I consent to the proposed dental treatment and authorize my dentist to perform the necessary procedures.

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

Dentist Name: _____

Dentist Signature: _____ Date: _____