

INFORMATION CONSENT AND TREATMENT CONFIRMATION

Patient's name _____ Date _____

I certify that I have read and understand all of this INFORMED CONSENT which outlines the general treatment consideration as well as the potential problems and complications of restorative/prosthetic treatment. I understand that potential complications and problems may include, but are not limited to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and the risks, as well as the potential consequences should I elect to postpone or refuse treatment. I understand that during and following treatment, conditions may arise that warrant additional or alternative treatment. I further understand that no guarantees can be made for a successful result.

Recognizing the potential problems and risks of restorative/prosthetic treatment, authorization is given for the dental treatment to be rendered by the dentist and office staff. I also approve, after full discussion of all aspects of my treatment, any modification in design, materials or care if it is believed to be in my best interest. In addition, I grant permission for my photographs of the procedures to be shown for teaching purposes only, provided my identity is not revealed.

Signed _____ Date _____
(Please initial each page to indicate that you have read and understood the content)

Witness _____ Date _____