Consent Form: Dental Treatment

Name of patient: _____ _____ _____ _____
Last Name | First Name | Father's Name | ID. No.

I declare and confirm that I received detailed verbal explanation from:

Dr. _____ _____
Last Name | First Name

regarding the need for dental treatment according to the treatment plan: (Add an extra sheet, if necessary)

_____

_____

_____

_____

_____

_____ (Hereinafter: the “Principal Treatment”).

I was informed about the Principal Treatment, including the expected results, chances, possible alternative treatments under the circumstances of the case and I considered the alternative treatments before choosing the treatment.
I also received explanation concerning the side effects of the Principal Treatment, including: pain, discomfort, swelling, infection, sensitivity to heat and cold and temporary limitation of mouth opening.

It was explained to me and I understand that during the Principal Treatment, it might become necessary to change the treatment plan, in whole or in part, including additional treatments which cannot be fully or definitely anticipated, including referral to specialist clinics and that I am aware of this option.
I am aware of the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the attending staff/doctor, including maintaining oral hygiene, receiving all necessary operative and prosthetic treatments and attending follow-up checkups on schedule, as required.

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after being informed of the risks and complications of anesthesia including sensation disorder in the lip and/or tongue and/or chin and/or face, subcutaneous hemorrhage, swelling and limitation of mouth opening. Should it be decided to perform the Principal Treatment under general anesthesia or under intravenous sedation, the anesthetic technique would be explained to me by an anesthesiologist.

_____ _____
Date | Patient’s Signature

_____ _____
Name of Guardian (relationship) | Guardian’s Signature (When patient is legally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient’s guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____
Name of Physician | Signature | License No.