

Baker Victory Dental Center

Consent for Dental Treatment

Procedures and Anesthesia

Patient's Name: _____

Date of Birth: _____

1. I hereby authorize Baker Victory Dental Center associates (dentists, hygienists) to perform routine dental treatment and/or anesthesia and to perform other intervention that their dental judgment dictates during said treatment.
2. I have been informed of the purpose of the treatment and the expected benefits and complications (from known and unknown causes), attendant discomforts and risk that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
3. I understand that during the course of the treatment, unforeseen conditions may arise which necessitate intervention different from those contemplated. I, therefore, consent to the performance of additional intervention which the dentist and/or associates may consider necessary.
4. I acknowledge that no guarantees have been made to me concerning the results intended from the intervention.
5. I confirm that I have read of have had the above read to me and fully understand and that all blank spaces have been completed prior to my signing.

Patient/Alternating Legal Guardian (if patient is under 18 years of age or unable to sign):

Signature

Print Name

Date

Relationship (if signed by person other than patient): _____

Dentist Certification:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/legal guardian fully understands what I have explained and answered.

Signature

Print Name

Date

THIS FORM MUST BE SIGNED BY THE INDIVIDUAL'S LEGAL GUARDIAN