Associated Dental Specialists of Long Grove

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CONSENT TO DENTAL TREATMENT

PATIENT'S NAME: _____
Last **First** **Initial** **Date of Birth**

After an examination, the dentist has explained that my dental condition is: _____

_____

The dentist has advised me of the following risks and consequences of the treatment: _____

_____

The dentist has advised me of the risks and consequences should I choose not to have this treatment done**:** _____

_____

The dentist has advised me of the following alternative treatments: _____

_____

The dentist has advised me of the following risks, advantages and disadvantages of these alternative treatments: _____

_____

I hereby authorize, _____ and whomever he
DOCTOR'S NAME

may designate as his assistants, to perform the following treatment or procedures: _____

_____

I realize that in spite of the possible complications and risks, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this treatment or procedure.

My child is allergic to the following antibiotics', drugs, medications and foods:

_____

I have provided as accurate and complete a medical and personal history as possible and will follow any and all instructions as explained to me and directed.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, and the risks and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

_____
Parent's Signature Date

I personally have explained the above information to the patient's parents or guardian.

_____
Dentist's Signature Date

_____
Witness' Signature Date