DENTAL PROCEDURE INFORMED CONSENT

Patient Name: _____

Date of Birth: _____

Name of Dentist: _____

Procedure to be performed: _____

Patient's Initials

_____ The details of the procedure, including the benefits and risks, have been explained to me in terms I understand.

_____ I understand and accept that the risks and complications have been discussed with me and may include but are not limited to:

-
- (List common complications/risks)
-

_____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any dental procedure.

_____ The risks and benefits of other possible treatments have been explained to me.

_____ I am aware that smoking or using e-cigarettes (vaping) or chewing tobacco before and after the procedure could increase the chance of complications. I have been advised to stop smoking, vaping, or using chewing tobacco.

_____ I have informed the dentist of my allergies and the medications that I am taking, including prescription medications, over-the-counter medications, herbal supplements, and aspirin. I have told the dentist about any use of recreational drugs and alcohol.

_____ I understand and agree that no guarantees about the results of the procedure have been made.

_____ I have been informed of what to expect after the procedure, including but not limited to: how long it will take to recover, how much pain to expect, how to treat the pain, and whether I will need additional procedures. I have been advised about what I can eat and drink and when I can resume my normal daily activities.

_____ Photos, images, and/or videos may be taken before, during, or after the procedure to include in my dental record. I understand that these photos, images, and/or videos belong to the dentist and are protected by federal and state privacy laws.

_____ I have been given a chance to ask questions, and the dentist has answered my questions to my satisfaction.

SAMPLE

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).

I certify that I have read and understand this treatment agreement and I agree to this procedure.

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment, and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Dentist Signature/Date/Time

SAMPLE

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).