ARLINGTON DENTAL BUILDING

INFORMED CONSENT FORM

I am aware that alternative procedures may be available, as well as the option to not proceed with the recommended treatment by the Dentist. I also understand that there are risks to this recommended treatment as well as to any treatment, as well as postponing or rejecting this recommended treatment.

I understand that dental visits may include examinations, preventative services and/or restorative procedures. Consent is required for each procedure at the time of each appointment.

I understand that radiographs may be required in order to complete examination, diagnosis, and treatment plan.

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination.

I understand that dentistry is not an exact science. I acknowledge that no guarantee has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care provided to me. I also understand that only the treating dentist is responsible for my dental treatment.

Do not sign this form or agree to treatment until you have read, understood, and accepted the information stated above

I certify that the Dentist has explained to me the treatment to be undertaken _____ Initial

_____ _____

Patient Signature Date

_____ _____

Patient Name Date

_____ _____

Parent/Legal Guardian Name Date

_____ _____

Witness Signature Date