Dental Procedure Consent Form

Patient Name:

Date of Birth:

Procedure:

Consent

I hereby authorize my dentist and designated staff to perform the proposed dental procedure as indicated above. I understand the nature and purpose of the procedure, the risks involved, possible alternatives, and the expected outcomes.

Risks & Complications

- [ ] Bleeding
- [ ] Infection
- [ ] Pain or discomfort
- [ ] Other (please specify):

Patient Statement

I have had the opportunity to ask questions and have them answered to my satisfaction. I understand that I may refuse or withdraw consent at any time before the procedure.

Additional Comments:

Patient/Guardian Signature

Date

Dentist Signature

Date