Doctor's Name ______________________

Address ______________________

Phone ______________________

INFORMED CONSENT

I was informed by the above named dentist, person on his staff or other practitioners to whom I have been referred by him/her, of the risks, potential alternative methods of treatment, and possible consequences in the treatment/therapies described below:

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Understanding this, I hereby authorize the above named dentist or persons designated by him/her to administer the above described treatment/therapy to me (or) to:

____

Name of patient if a minor

Signature: ______________________

Patient or Person Authorized to give consent for minor patient

Signature: ______________________

Dentist

Signature: ______________________

Witness

Date: ______________________

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