BRSH

Cosmetic & Comprehensive Dentistry

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DENTAL TREATMENT CONSENT FORM

I believe the health history which I have reviewed and signed to be accurate and complete and all the information provided may be of importance to my oral and physical health.

I consent to the following treatment(s):

Examination:

Examination may include, but is not limited to radiographs, oral cancer screening, periodontal charting and diagnosis, soft and hard tissue examination, intraoral photos, and any recommended procedures for proper evaluation and diagnosis of oral conditions.

Prophylaxis (Routine Cleaning):

Possible complications of a prophylaxis may include, but are not limited to pain, bleeding tissue/gums, tissue/gum laceration, sensitivity to temperature, foods and beverages, swelling, ulceration, tooth fracture, crown fracture or breakage of fillings. Fluoride treatment or polishing paste may be recommended. Possible complications may include, but are not limited to allergic reaction, nausea or vomiting.

I understand that dentistry is not an exact science and that, therefore, reputable dentists cannot fully guarantee results. I acknowledge that there is no guarantee or assurance regarding the dental treatment, which I requested and authorized.
I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient/Guardian_____Date_____