Leo Dentistry

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CONSENT FOR DENTAL TREATMENT

I request and consent to a surgical procedure called, _____.

I understand that the purpose of this procedure is _____.

(Practitioner must describe in non-medical terms)

This procedure will be performed by _____.

I have been advised that this procedure may have potential benefits, risks, or side effects associated with it, including, but not limited to,

_____.

Including potential problems that might occur during recuperation, I have been advised of the alternatives, the risks, benefits and side effects related to the alternatives.

*I consent to the administration of anesthesia and related drugs, as deemed necessary by the staff members from *LEO DENTISTRY DBA*.

*I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.

*I impose no specific limitations or restrictions on my treatment other than,

_____.

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. All blank spaces are completed or lined out, prior to my signing this document.

Date Patient Signature

_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient Signature

_____

Date Witness Signature

_____