Consent Form for Dental Treatment

Name of patient: _____
Last Name First Name I.D.

I declare and confirm that I received a detailed verbal explanation from:
Dr. _____
Last name First Name
regarding the need to perform dental treatment. Details of the treatment plan: (Add an extra sheet, if necessary)

_____
_____
_____
_____
_____ (hereinafter: the "Principal Treatment").

I declare that the Principal Treatment, including the expected results, chances, possible alternative treatments under the circumstances of the case, and the examinations and treatments involved, has been explained to me. I considered the alternative treatments before choosing the Principal Treatment. I also received explanations of the side effects of the Principal Treatment, including: pain, discomfort, swelling, infection, and sensitivity to hot and cold.
Furthermore, I hereby declare and confirm that it has been explained to me and that I fully understand that during the Principal Treatment, it might become necessary to change the treatment plan, in whole or in part, including additional treatments which cannot be fully anticipated, including referral to specialist clinics (oral surgery, root canal treatments, gingival (gums) treatments etc.) and that I am aware of this possibility.
I am aware of the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff/doctor, including maintaining oral hygiene, receiving all necessary operative and prosthetic treatments and attending scheduled follow-up checkups, as necessary.
I hereby give my consent to the Principal Treatment.
My consent is also given for local anesthesia, after the risks and complications of anesthesia including temporary limitation in the ability to open my mouth, were explained to me.

_____
Date Patient's Signature

_____
Name of Guardian (relationship) Guardian's signature
(when patient is legally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian* all the aforementioned in detail, as required, and that he/she signed before me, after I satisfied myself that he/she fully understood my explanation.

_____ _____ _____
Name of Physician Signature License No.

* delete if inappropriate

MRM
החברה לניהול סיכונים ברפואה בע"מ
מקבוצת מדנס