AUTHORIZATION & CONSENT TO TREATMENT AND/OR SURGERY

Patient Name: _____

This authorization and consent for treatment is given to my Manus dentist, Dr. _____ hereinafter referred to as Doctor, after having first had a full explanation of the proposed treatment, alternatives and risks.

Doctor has explained that his diagnosis, based on the information gained in the examination has been given to me. Doctor has provided me with a consultation report of his findings and a treatment proposal/fee schedule.

1. Doctor has advised me that there are certain risks and potential consequences of any treatment plan or procedure.
2. Doctor has advised me that in dentistry, as in medicine, no one can predict a successful outcome with certainty and that even with treatment my condition could worsen.
3. I understand that no guarantee or assurance has been given to me that the proposed treatments or alternatives, if any, would fully satisfy my expectations. I believe that it is in my own best interest to proceed with the proposed treatment(s).
4. I have had ample opportunity to ask any questions about the proposed treatment, alternatives and risks. All questions that I have asked have been fully answered to my satisfaction.
5. I agree to follow the post-treatment care instructions given to me by the Doctor and I agree to abide by his professional judgment. I realize that my failure to properly care for my oral health subsequent to treatment may lead to the failure of the treatment.
6. I have had the opportunity to discuss with the Doctor my medical and health history indicating any serious problems, injuries or allergies.

7. Attached to this document is the specific treatment outline and the anticipated cost associated with your prosthetic treatment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT, MEDICATION OR SURGERY DESCRIBED ABOVE. I ACCEPT THE RISKS OF SUBSTANTIAL HARMS, IF ANY, IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULTS OF THIS TREATMENT OR PROCEDURE. I HAVE READ AND UNDERSTAND THE FEE OUTLINE FOR TREATMENT AND AGREE TO BE RESPONSIBLE FOR ALL FEES ASSOCIATED WITH SAID TREATMENT. I FURTHER ACKNOWLEDGE THAT ALL BLANKS ON THIS FORM REQUIRING COMPLETION HAVE BEEN FILLED IN OR DELETED, IF NECESSARY, PRIOR TO MY SIGNING THIS FORM.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian (if applicable) Date

_____ _____
Doctor Witness