Dental Consent Form

Name of the Hospital: _____

Personal Information: _____

_____

Name of the dentist: _____

Name of the Patient: _____

Date of Admission: _____

Dental consent terms:

Are you ready for the change in your dental treatment as suggested by the doctor?

_____

Have you understood the medicines referred for your dental cavities?

_____

Have you done the x-ray of your teeth? _____

Would you like to go for root canal treatment to get rid of pain? _____

If the root canal condition found serious, are you ready for the removal of your teeth:

_____

Please mention if you are taking some other medicines to treat your teeth ache:

_____

Have you understood the full terms of periodontal loss in case of failure of treatment or any medicine reaction? _____

Reset Form

Can we take your repose as the final dental consent decision for the above mentioned?

_____

Signature of the patient: _____

Signature of the parent if minor: _____

Date: _____

Sample Forms Reset Form