Parkwest DENTAL

General Consent for Treatment

I have been given the opportunity to ask any questions regarding the nature, risks, benefits, alternatives (including no treatment), and costs of the proposed treatment(s) and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, which may be associated with any phase of this treatment plan in hopes of obtaining the desired results, which may or may not be achieved. The fees for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize the doctor and other providers to render any services they deem necessary or advisable to treat my dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications. Any medications dispensed or prescribed are my responsibility to understand before taking. Particular attention should be given to possible allergic reactions, drug interactions with current medications, and their specific side effects.

During the course of treatment the treatment plan may change. If a change to the treatment plan is required any and all changes will be explained to me and will require additional consent. I understand that dentistry is not an exact science and that a precise outcome or perfect result is not guaranteed.

If I develop a complication it is my responsibility to notify the provider and/or staff. Through this notification they will be able to act on your behalf. Attempts to address the issue may occur at this office or a referral to another health care practitioner may be warranted.

I understand that if no treatment is performed, I may continue to experience symptoms which may increase in severity, and the cosmetic appearance of my teeth may (continue to) deteriorate.

After discussing the dental treatment as well as alternatives to the treatment, including no treatment, and the possible risks and complications involved during and after the performance of the treatment with my dental provider at Park West Dental, and after having an opportunity to ask any and all questions regarding the proposed treatment and having my questions answered to my satisfaction, I hereby authorize and consent to administration of medications and the dental treatment as set out in the treatment plan which I signed.

- ☐ I hereby authorize and consent to administration of medications and the dental treatment as set out in the treatment plan which I signed.
- ☐ I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship to Patient

_____ _____

Signature of Doctor Date