Dental Consent and Authorization Form

Please review each section carefully and provide your consent and acknowledgment for dental examinations, treatments, and related procedures.

Patient Information

Please provide your personal details.

Patient Full Name *

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address *

Consent for Examination & X-Rays

Please review and provide your consent.

I consent to the following (select all that apply): *

- ☐ Dental examination
- ☐ Dental X-rays as deemed necessary
- ☐ Routine dental cleaning

Consent for Dental Treatment

Please review and provide your consent.

I consent to the following dental treatments (select all that apply): *

- ☐ Restorative treatment (fillings, crowns, etc.)
- ☐ Preventive treatment (fluoride, sealants, etc.)

☐ Other dental procedures as recommended by the dentist

Risks & Complications Acknowledgment

Please acknowledge the following potential risks.

I acknowledge that the following risks and complications may occur (select all that apply): *

☐ Sensitivity or discomfort after treatment
☐ Infection or delayed healing
☐ Unexpected reaction to medications or anesthesia
☐ Need for additional or future dental procedures
☐ Other unforeseen risks

I have had the opportunity to discuss these risks and all my questions have been answered. *

☐ I acknowledge and accept the above risks and complications.

Local Anesthesia & Pain Management

Please indicate your consent and provide additional information if necessary.

Do you consent to the use of local anesthesia and pain management as recommended? *

◯ Yes, I consent
◯ No, I do not consent

If you answered 'No' or have concerns about anesthesia, please explain:

I acknowledge that I have discussed anesthesia and pain management options with my dentist. *

☐ I acknowledge and accept the anesthesia plan discussed.

Medications, Allergies & Health Conditions

Please inform us of any relevant health information.

Do you have any allergies, current medications, or health conditions we should be aware of? *

◯ Yes

◯ No

If yes, please list all allergies, medications, or health conditions:

Financial Responsibility

Please acknowledge your understanding of financial responsibility.

I acknowledge and accept the following (select all that apply): *

- ☐ I am responsible for payment of all dental services provided.
- ☐ I understand my insurance may not cover all procedures.
- ☐ I agree to pay any balances not covered by insurance.

Emergency Treatment Authorization

Please authorize emergency treatment if necessary.

In the event of a dental emergency, I authorize the dentist to provide necessary treatment. *

- ☐ I authorize emergency dental treatment as needed.

HIPAA Privacy Acknowledgment

Please acknowledge your understanding of privacy practices.

I acknowledge the following (select all that apply): *

- ☐ I have received and reviewed the dental practice's HIPAA Privacy Policy.
- ☐ I understand how my health information may be used and disclosed.
- ☐ I may request a copy of my health records at any time.

Consent Confirmation & Signature

I confirm the following (select all that apply): *

☐ I have read and understand all information provided in this form.
☐ All my questions have been answered to my satisfaction.
☐ I voluntarily consent to the proposed dental treatment(s).

Patient (or Legal Guardian) Name *

Signature