ORTHOPROS

Dental Treatment Consent Form

Patient name: _____

Dental Care Team Representative: _____

We appreciate the confidence you have placed with us to provide your dental care.

I understand that dentistry is not an exact science and there is no guarantee of specific results. For the best results, it is imperative that I work together with the dental care team. This means that I will strive to keep all appointments and arrive on time. Cooperation and participation is imperative for the desired outcome.

I understand the dental care team will recommend procedures. The dental team will do their best to make sure I understand their care and plan. If I do not understand any of the treatment or plan, I will discuss it with the dental team. I understand that if I do not fulfill my part of the agreement by following their advices, I will be hampering the outcome of my treatment.

I understand that should I feel there are changes in my condition or symptoms appear between scheduled visits, I should notify the office immediately.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Dental Care Team Representative Date