SCARSDALE DENTAL SPA
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CONSENT TO TREATMENT

Patient Name: ______________________________ **Date:** ______________

CONSENT:

This informed consent and authorization is given to Dr. ______________________________
after having first received a full explanation of the proposed treatment, alternative treatment and treatment risks. Based upon my symptoms and the full examination I have received, I have been advised that I have the following condition:

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TREATMENT:

I hereby authorize and consent to the following procedure(s):

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ALTERNATIVE TREATMENT:

I have been advised that alternate treatment exists, which may include but is not limited to:

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☐ I have, however, elected to treat my condition by the proposed treatment rather than any alternative treatment.

TREATMENT RISKS:

I understand that inherent to any procedure, and because of an individual's variations, certain risks are involved with this treatment. They may include, but are not limited to:

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ADDITIONAL COMMENTS:

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By signing below, I acknowledge that I have read this document, understand the information presented, and have had all my questions answered satisfactorily.

Patient: ______________________________ Date: ______________
(Or Person Authorized To Consent For Patient)

Doctor: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________