

STANDARD CONSENT FORM- ORAL HEALTH

I Mr. Mrs. Miss., DOB.....
 Ofhereby fully understand the said treatment and its associated risks as listed below that was explained to me. I have been explained about the reason for treatment and other alternative treatment options available.

I do give my consent to the said procedure and any further treatment that may arise as a result of the initial treatment. I do understand that the treatment may not provide the expected result as planned even though the treatment is carried out with due professional care.

TREATMENT/PROCEDURE	Signed	Witness	DATES
1.
2.
3.
4.
5.

Risks associated with Dental Treatments

	Post-Operative Pain	Post-operative bleeding	Post-operative swelling	Post-operative infection	Soft/hard Tissue trauma	Nerve Injury	Tooth mobility/ Loss	Occlusal derangement	TMJ problem
Mandibular Fracture	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surgery for impacted teeth	✓	✓	✓	✓	✓	✓	✓		✓
Alveoplasty	✓	✓	✓	✓	✓	✓	✓		
Soft tissue surgery	✓	✓	✓	✓	✓	✓			
Extraction	✓	✓	✓	✓	✓	✓	✓	✓	✓
Root recovery	✓	✓	✓	✓	✓	✓	✓		✓
Periodontal Treatment	✓	✓	✓	✓	✓				
Conservative Treatment	✓			✓	✓	✓	✓		
Endodontic Treatment	✓			✓	✓	✓	✓		
Prosthetic Treatment	✓		✓	✓	✓	✓	✓	✓	✓
Orthodontic Treatment	✓		✓	✓	✓	✓	✓	✓	✓