

Treatment Consent Form *(Prior to Treatment)*

To be Read ...by Patient *and/or* Patient's Parent / Legal Guardian

I understand that the general nature of the dental procedure(s) that can improve my dental health will be explained to me. I understand that I will be provided an opportunity to ask questions before treatment. And, I know that I will be allowed to ask questions at any time during my treatment.

I understand that a working plan will be presented to me, prior to treatment, and that this plan can change as my treatment progresses. I understand that if this occurs, I will be informed.

I understand that it will be explained to me what part, if not all, of my treatment, Dr. Jim Dick plans to do at this time. I understand that it may be discovered, at a later time, that some of the treatment planned may not be able to be done by Dr. Dick; and, if that occurs, I will be informed.

I understand that I have the right to refuse any part of, or all of, the planned treatment. I also understand that the refusal of some types of care greatly limits what Dr. Dick can do, and in some cases, may cause Dr. Dick to stop treatment. I understand that if this is true in my case, I will be informed.

I understand that no promise or guarantee can be made as to the results of treatment. Dr. Dick will do everything he can, ethically and professionally, to provide the best of care.

I understand and agree that other clinical personnel in the office of Dr. Jim Dick may provide this treatment, as appropriate, under the direction of Dr. Dick. I also understand and agree that other clinical personnel in the Office of Dr. Jim Dick may assist Dr. Dick in the procedure(s), or observe in my treatment, under the direction of Dr. Dick.

I hereby authorize and consent to treatment for the below named patient.

PRINT Patient's Name:

First	Last	MI

SIGNATURE of Patient *(or Parent/Legal Guardian)*:

Date

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PRINT Parent's/Legal Guardian's Name:

First	Last	MI