CENTRE DENTAIRE
JARDINS DORVAL

Consent to Treatment

Name of Patient ______________________________

Date ____________________ Expected Duration of Treatment ____________________

1. I authorize **Dr. Sirhan** to perform the following procedure and treatment ____________________

And if during the course of such treatment in his opinion and judgment any treatment or procedure different from that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, I further request and authorize him to do whatever he considers advisable.

2. The nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by **Dr. Sirhan**

3. I acknowledge the no guarantee or assurance has been made to me as to the results that may be obtained
(possible lower lip numbness or tongue numbness and anesthesia discussed)

4. I consent to the administration of local anaesthetics or any such other anaesthetics as may be considered necessary or advised by those dentist referred to in this consent under whose care I place myself.

5. Are you currently pregnant? Yes ☐ No ☐

I Certify that I have read and fully understand the above consent to the treatment and that the explanations therein referred to were in fact made to me and that the form was filled in prior to the treatment

Signature of Patient ______________________________

or

Signature of Parent or Guardian ______________________________

Relationship of person Signing to Patient ______________________________

Note: When patient is a minor or is otherwise incompetent to give consent, the consent of a parent or guardian must be obtained.

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed

Signature of Witness ______________________________