Dental Treatment Consent

Informed consent. The dentist fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

DENTIST NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

TREATMENT PLAN

ESTIMATED COST (₹)

SITTINGS

START DATE

Routine dental care includes check-ups, dental X-rays, scaling and polishing, fillings and local anaesthesia. If the plan changes during treatment, the dentist will explain and confirm the new cost before proceeding.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Sensitivity or soreness after fillings or scaling
- Numbness from local anaesthetic, rarely lasting longer than a day
- Fillings may wear, chip or need replacing
- Allergic reaction to materials or medicines

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- A different filling material (composite, GIC, amalgam, inlay)
- Delaying treatment, which may make it more extensive later

Your health

Do you have heart disease, diabetes or a bleeding disorder?

○ No ○ Yes

Are you pregnant?

○ No ○ Yes

Are you allergic to local anaesthetic or penicillin?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The dentist has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Dentist

SIGNATURE

PRINTED NAME

DATE