Clinton Dental
580 College Street
Toronto, Ontario
M6G 1B3 416-588-8883
dentistry@clintondental.ca

CONSENT FOR TREATMENT

I, _____, hereby authorize Clinton Dental to perform the procedure(s) or course(s) of treatment listed. I understand my dental condition and have discussed several treatment options with the doctor. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I have discussed payment options and am aware that ALL PAYMENT is DUE IN FULL on the date of the service unless otherwise discussed and or agreed upon prior to treatment. I am also aware that there may have to be revisions in costs to treatment of long duration. The revisions will be discussed with me before the treatment is begun.

I confirm that I understand this form and the information contained therein.

Signature of Patient:_____
(Parents or guardian must sign for dependents under 18 years of age)

Witness:_____

Date:_____