Portway Dental Practice

Discussion and Consent for Treatment

Patient's Information

Surname Forename

Date of Birth

Address

I acknowledge being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning treatment, I wish to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and that it is better to as them before treatment begins than to wonder about it after treatment has started.

Nature of Recommended Treatment

It has been recommended that I have the following treatment:

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my dentist's knowledge of my medical and dental history. My needs and desires have also been taken into considerations.

The treatment is necessary because of the following condition(s)

- ☐ Pain
- ☐ Infection
- ☐ Periodontal (gum) disease
- ☐ Decay
- ☐ Broken tooth/Teeth
- ☐ Other

The intended benefit of this treatment is:

The prognosis, or likelihood of success, of this treatment is:

My treatment is estimated to take visits to complete, but I understand it could be shorter or longer based on what happens when treatment begins.

My treatment is estimated to cost £ . I understand this is only an estimate and that I will be informed as soon as possible if the cost estimate changes.

Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative methods to treat my dental condition include:

No other reasonable treatment options exist for my condition.

[Forename/Surname] I have had an opportunity to ask questions to ask questions about these alternatives and any other treatments I have heard of thought about, including:

Risk of recommended treatment

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity.

These include:

[Forename/Surname] I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about:

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and I will permit the recommended diagnostic procedures, including X-rays.

I have realised that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of the procedure.

I, [Forename/Surname], have received information about the proposed treatment, I have discussed my treatment with Dentist [ ] and have been given an opportunity to ask questions and have them fully answered. I understand the nature if the recommended treatment, alternate treatment options, and the risks of the recommended treatment

I wish to proceed with the recommended treatment.

Specialty Treatment Acknowledgement (if applicable)

[Forename/Surname] I understand that this procedure can also be performed by a (a dental specialist). I understand the risk and elect to have this procedure performed by Dentist .

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[Forename/Surname] I understand that if any unexpected difficulties occur during treatment, I may be referred to a for further care.

Forename

Surname

Signed