*St George's Dental Practice*

TEL : 01257 262545
19-21 ST GEORGES STREET,
CHORLEY, LANCASHIRE, PR7 2AA

St. George's
Dental Practice

**PATIENT CONSENT FORM**

(WITHOUT SEDATION)

Name of Patient : …………………………………………………………………………………………………………………………………………….
Name of Parent or Guardian : ……………………………………………………………………………………………………………………….
Address…………………………………………………………………………………………………………………………..……………………………
……………………………………………………………………………………………………………………………………………………………………..

I hereby consent to the following dental treatment for ……………………………….. as explained to me by Dr……………………………………. on ………/…………/……….

Treatment:
……………………………………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………………………………

Dr …………………………………………………………..……. has explained;

| | |
|---|---|
| The nature of the treatment and why it is necessary | Yes/No |
| The advantages and disadvantages of the treatment | Yes/No |
| The alternatives that are available | Yes/No |
| The significant risks and side-effects | Yes/No |
| What might happen if the treatment is not carried out | Yes/No |

I have been given the opportunity to ask questions and time to consider the treatment options. I understand that if there are any changes needed to the proposed treatment, the reasons will be explained, and I will be asked for my consent.

I have been advised that I can change my mind and withdrawn my consent at any time.

Signature : ………………………………………………………………………………………….. Date : …………………………………………….
Name of Parent or Guardian :

I confirm that I have obtained a full medical history and explained to the person who signed the above form of consent, in terms which in my judgement are suited to their understanding, the nature, purpose, risks and alternatives of this treatment and that the anaesthetic techniques and usual pain control procedures have also been explained.

Signature : ………………………………………………………………………………………….. Date : …………………………………………….