Bruce J. Milner D.D.S

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Consent to Dental Treatment

Patient Name:_____ **Date:**_____

I hereby authorize Dr. Bruce Milner and /or any such assistants as may be selected and supervised by him to provide me with dental treatment.

The nature, purpose and procedures of the proposed treatment have been explained to me and I understand them.

The risks, benefits, and possible complications of the proposed treatment, including the risk that such treatment may not accomplish the desired objective, have been fully explained to me.

I understand the success of the dental treatment cannot be determined in advance and I acknowledge that no guarantees have been made to me regarding the results of this treatment.

Should complications occur, I understand other procedures may be necessary.

I have been advised of the advantages and disadvantages of possible alternative treatments and my prognosis if no treatment is received. Any questions I have regarding the nature, purpose and procedures of the proposed dental treatment have been answered to my satisfaction.

I have had the opportunity to read the form, ask questions, and have had my questions answered to my satisfaction. I hereby consent to the proposed dental treatment.

_____ _____

Signature of Patient or Guardian **Date**

I have personally explained the above information to the patient or the patient's guardian.

_____ _____

Signature of Doctor **Date**

_____ _____

Signature of Witness **Date**