Third Party Consent Form

Patient ____________________

Date ______________________

It is necessary to obtain consent before examination or treatment. Please read the following paraphrases and sign your name in the appropriate place if you consent to treatment in this practice of the minor patient named above.

I hearby consent to the operations, procedures, techniques, or clinical photographs which the dentist in attendance deems necessary for the treatment of the patient named above. I authorize the dentist to provide any information to other doctors for the purpose of consultation.

I understand that prior to any treatment that I will be advised about it by the dentist, that I may ask questions concerning it, and that I may revoke this consent before treatment is provided.

I further understand that post-operative complications (for example: bleeding, pain, and swelling) may be a normal consequence of the treatment rendered. I understand that I may ask for a full recital of any or all risks attendant to the care of the above named patient.

Date ____________ Signed __________________________________ Relationship to Patient ______________________

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