



## INFORMED CONSENT FOR DENTAL TREATMENT

**Provider Office**

Provider Name:		Office ID#:	
Address:		Office Phone:	
City:	State:	Zip:	Office Fax:

**Member**

Member Name:		Member ID#:	
Address:		Date of Birth:	
City:	State:	Zip:	Phone:

Type of Dental Procedure					
Tooth/Area	CDT Code	Procedure Description		Accept	Decline

As the dentist, I have explained to the member, his/her treatment, risks and benefits, and costs associated with the dental treatment/ procedure. **Signature is required.**

The dentist explained the nature of the treatment and how it will help me. I understand the risk and complications if I do not follow the instructions given to me after the procedure which involves post-treatment and follow-ups. **Signature is required.**

Provider Name

Member Name

Provider Signature

Member Signature

Date

Date