Sample Consent to Treatment Form

Name of Patient ______________________________

Date ______________________ Expected Duration of Treatment ______________

1. I authorize Dr. ______________________________ , or whomever he/she may designate to perform on ______________________________

(Name of patient - or myself)

the following procedure(s) and treatment:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

(State nature of procedure(s) and treatment and, if anesthetic is to administered, the type of anesthetic to be used)

If during the course of such treatment as described above, in Dr. ______________________’s opinion and judgment or whomever he/she may designate, any treatment or procedure different from that now contemplated should be indicated for which there is no reasonable opportunity for additional explanation and authorization, I further request and authorize Dr. ______________________ , or whomever he/she may designate, to do whatever they consider advisable.

2. The nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me by

____

(Name(s) of dentist(s) explaining)

including the following information on alternative methods of treatment, including no treatment, risks and possible complications (insert information below):

____

____

3. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. The average life expectancy of the treatment(s) described in paragraph 1 has been provided.

4. I consent to the administration of the anesthetics named above (if any) or any such other anesthetics as may be considered necessary or advisable by the dentist(s) referred to in this consent.

5. I understand that this Consent to Treatment form and the treatment provided as described in paragraph 1 above will be governed by the laws of the Province of ______________________ and I consent to the Courts of the Province of ______________________ having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment or on any other grounds whatsoever, and whether against the dentist(s) named in paragraph 1 or against any of his/her partners, associates, employees or staff.

I undertake and agree to not commence any action relating to such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment, or on any other grounds whatsoever, in any other legal jurisdiction outside of the Province of whether or not I may have a right to do so.

I acknowledge and understand that Dr. ____________________ has agreed to provide professional services for me conditional on this undertaking being given and honoured by me with regard to my declaring that the Province of ____________________ has exclusive jurisdiction over any action, suit or proceeding and Dr. ____________________ has made it clear that without my making this undertaking, he would not have agreed to provide treatment for me.

6. I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment described in paragraph 1 with Dr. ____________________ and that I have agreed to make such payment on the terms we discussed.

BY INITIALING HERE " ____________", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED.

BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

Signature of Patient ____

or

Signature of Parent of Guardian ____

(or other person authorized to consent for patient)

Relationship of Person Signing to Patient ____

Note: When a patient is a minor and/or is otherwise incapable of consenting to the treatment, the consent of a parent, guardian or substitute decision maker must be obtained.

Date: ____________________

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness ____

Date: ____________________