

Dear Doctor,

As an insurer, we deal with each insured and the malpractice claim against them on an individual basis. Professional Solutions does not take a position regarding informed consent, informed refusal or other topics which may be addressed in various form documents. If Professional Solutions had such views or guidelines it could prove detrimental to other insureds' and their claims.

As for the various forms themselves, we have always maintained the policy that we do not review any individual forms nor will we endorse any particular form. We do offer the following guidelines as you consider forms, either those you create yourself or use from other sources.

Most importantly, remember that Informed consent and/or informed refusal are processes, which may or may not be satisfied with a written form. It is an educational process which takes place between the dentist and the patient and/or their legal representative.

It is the doctor's responsibility to make sure the patient is properly informed, understands and consents to the treatment to be provided. It is however also within the doctor's discretion as to how the information is communicated and how the consent or refusal is obtained; both should be documented.

Generally, the legal concept of informed consent arises from the principle that absent extenuating circumstances, a patient has the right to exercise control over his or her body by making an informed decision concerning whether to consent to a particular course of treatment or procedure. For the patient to truly consent it is generally held they should know and completely understand the following:

- Nature of the treatment to be rendered;
- All material risks attendant to that treatment;
- The possibility of an occurrence of the risks;
- Alternative treatment available and the risks attendant to those treatments;
- The consequences of allowing the condition to remain untreated.

Therefore your informed consent should strive for:

- A clear, concise explanation of the purpose and nature of the treatment being recommended along with the risks, benefits, options, alternatives and risk of choosing no treatment
- Disclosure of the patient's necessary involvement
- Acknowledgement and comprehension by the patient and/or their legal representative of pursuing the recommended treatment
- The voluntary choice to proceed with the service

The consent form must be written in easy to understand language which assures the patient's comprehension. Therefore, technical terms and abbreviations should be avoided as well as complex sentences. Type face and spacing of the paragraphs should allow for ease of reading, comprehension and understanding. The general rule is that the language should be common and ordinary and written at a 5th grade reading level. The statements should be written in second person, using the pronouns of "you" or "your", thus personalizing and internalizing the actions. The sentences should not be assumptive but rather presumptive. Fee or financial information should not be included in your consent forms.

Included here are various sample forms for illustrative purposes only to assist you with creating your own forms should you choose to do so. You will not be able to use these forms as-is. These are to be used as a template only for you to create your own forms and processes to fit the special needs of your practice and the situation using the guidelines noted above.

We encourage you to refer to other resources, such as dental associations or dental literature to further tailor these forms and processes and to assist with periodic review and updates. We encourage you also to regularly update your patient information and consent as part of this process. Your forms should always be dated and when/if a form is updated or replaced; a copy should be maintained as reference for your practice protocol during the time period utilized.

Even though the principles stated above have been generally well accepted throughout the country, specific state statutes or state case law often further define the necessary elements to establish informed consent.

Because of the possible peculiarities in any given state, we believe you would be best served by contacting an attorney in your state who practices health care related law and ask that person to advise you regarding your particular practice. In this way, you will have the benefit of an attorney who should be current on the informed consent issue in your state. The attorney can advise you whether there are any specific informed consent laws which might impact your practice and whether use of an informed consent form would be prudent.

From our experience when a health care provider gets sued for malpractice, often times an allegation is made there was no informed consent given by the patient. Again, Professional Solutions maintains no position on this issue, but rather, leaves the decision up to the practitioner.

We hope this information is helpful.

CROWNS & BRIDGES

Patient Name: _____

Date: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing dental treatment with crown and/or bridgework, there are certain risks and the potential for unsuccessful results including the possibility of failure of the procedure. Crown and/or bridgework will require multiple appointments. There is no guarantee of the lifetime of the crown and bridgework.

Crown and/or bridgework have been recommended to me after careful examination and diagnosis.

Crown restorations cover and protect teeth which have been weakened by decay, other restorations or root canal therapy. Crowns can also be used for cosmetic purposes.

Bridgework replaces missing teeth. The bridge covers the gap (bridges) of the area between the nature teeth and where an extraction has taken place. Bridges can also help to maintain the position of teeth thereby retaining the contours of the face and aid in chewing ability.

Alternatives to crown placement includes:

- Restoration by other methods such as onlay, inlay, veneer, or filling
- Extraction with possible replacement with an implant, denture or fixed bridge
- No treatment which may result in pain, swelling, infection, or loss of teeth

Alternatives to bridgework include:

- Dental Implants;
- Partial dentures which are removable and supported by adjoining teeth
- No treatment which may result in shifting of the adjacent teeth, chewing, gum or joint pain

Treatment with crown and bridgework may involve the following risks:

- Injury to a nerve as a result of anesthesia administered during the procedure resulting in numbness, burning or tingling of the chin, lip, cheek, gum on the side on this the procedure in being performed as well as loss of taste in the case of the tongue. These nerve injuries can last for several weeks, months or in rare instances, be permanent
- Mild to severe sensitivity of the teeth
- Root canal treatment to adjacent teeth may be necessary due to trauma, decay or extensive preparation for the crown and bridge
- Breaking or chipping of the crown and bridge
- Uncomfortable feeling in the mouth which may lead to muscle soreness or temporomandibular joint pain
- A change in speech and/or appearance

Once crown and/or bridgework starts, it is imperative the treatment be completed and additional appointments may be required. Care must be taken during the time a temporary crown is placed to ensure it stays on until the final crown is delivered. Failure to keep the cementation appointment can lead to the ultimate failure of the crown and bridgework to fit properly.

Cosmetic results as a result of crown and bridgework are subjective thus the outcome may not completely meet my expectations.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

IMPLANT SURGERY & PROSTHETICS

Patient Name: _____

Date: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing Implant Surgery with Prosthetics there are certain risks and the potential for unsuccessful results. In order to minimize these outcomes, once treatment begins complete cooperation and participation is necessary.

The surgical procedure of placing dental implants has been recommended to me by Dr. _____ after careful examination.

Dental Implants with prosthetics offer the benefit of replacing missing natural teeth and offers support to dentures.

Dental implants are metal screws known as anchors which are set securely in the jawbone underneath the gum line as a substitute for the tooth roots. Posts are attached to the implants and artificial teeth are fastened to the posts.

The dental implant process typically requires two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. The gums are then stitched closed. A temporary denture may be worn for a few months while the anchors bond to the jawbone and the gums and bone heal. The second procedure will uncover the implants to allow for the posts to be attached. After the posts are attached, the replacement teeth in the form of a fixed or removable bridge or a denture are fastened to the posts. Depending on your specific condition, bone grafting or guided tissue regeneration might also be necessary to install the anchors and posts.

An alternative to dental implants with prosthetics, depending on the condition of my mouth and diagnosis include but are not limited to:

- A fixed bridge supported by natural teeth next to the toothless space
- A removable partial denture or full denture
- No treatment which may result in shifting of the adjacent teeth over time leading to chewing or gum problems

I understand there are risks, potential complications and side effects with any dental procedure. Some of the possible risks associated with this procedure include, but are not limited to:

- Swelling and discomfort postoperatively
- Bleeding and postoperative infection accompanied by malaise or fever which may require immediate additional treatment
- Injury to adjacent teeth or their roots may occur which will require further dental care
- Injury to a nerve resulting in numbness, burning or tingling of the chin, lip, cheek, gum on the side on this the procedure in being performed as well as loss of taste in the case of the tongue. These nerve injuries can last for several weeks, months or in rare instances, be permanent.

- Muscle or jaw restriction of the mouth opening for several days or weeks as well as possible temporomandibular joint (TMJ) pain or dislocation
- In rare circumstances breakage or bone loss of the jaw
- Sinus involvement which would require additional surgery
- Failure of the implant
- Drug and medication reactions, although rare, may occur. These reactions could include redness, swelling, pain, itching, vomiting and/or anaphylactic shock

Most complications and risks are not serious or happen infrequently although could result in the necessity of repeating the treatment, additional dental care or treatment by another medical specialist. In very rare occasions, complications could result in permanent disability or death. I understand the use of tobacco products in any form and certain medical conditions such as diabetes can increase the risk the implant will fail and require removal.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

ORAL SEDATION/ANESTHESIA

Patient Name: _____

Date: _____

Oral Sedation and Anesthesia are methods to reduce pain and relieve anxiety.

Oral sedatives such as Valium, Halcion, Ativan, or other (please insert name):
_____ may cause dizziness, drowsiness, fatigue or affect motor skills co-ordination.

Anesthesia includes:

- Local anesthesia (Novocain, Lidocaine, etc.) will block the pain pathways and is given in a specific area.
- Intravenous sedation or general anesthesia alters your awareness of the procedure by inducing a sedative/amnesic affect or sleep. Intravenous sedation is not sleep and responsiveness is maintained.

Whichever technique chosen to reduce/eliminate pain, certain risks are involved. These risks, while not common, include but are not limited to:

- Nausea and vomiting
- An Allergic reaction. An Allergic reaction might cause more serious respiratory or cardiovascular problems such as heart attack, stroke which may require treatment from another medical specialist. Death can occur
- Pain, injury to the nerves or blood vessels, swelling, inflammation or infection could occur at the site of the injection

I have read and understand the risks associated with anesthesia and give my consent for Dr. _____ to use (circle one):

1. Local Anesthesia only
2. Intravenous (IV) sedation with local anesthesia
3. General anesthesia with local anesthesia

I am confirming I have given a complete, up-to-date and truthful medical history to include all medications, drug use, pregnancy status, etc. which might be affected by or affect the use or outcome of the sedation.

I am confirming that if I have chosen IV sedation or general anesthesia I have received pre-operative instructions and as a result I have not had any solids or liquids by mouth for the ten hours prior to my dental surgery. Medications may be taken with a sip of water. I understand that having consumed any solids or liquids could be life threatening.

I understand medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. Therefore, I have been advised not to work or operate any vehicle or hazardous devices, supervise or care for children or perform any function that requires coordination or personal judgment while taking such medication or consume alcohol or other drugs because they can increase the effects of the medications. I understand full recovery can take between 24 to 48 hours.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

SAMPLE

GENERAL DENTISTRY CARE CONSENT FORM

Patient Name: _____

Date: _____

Dental Care Team Representative: _____

Welcome to our office. We appreciate the confidence you have placed with us to provide your dental care.

I understand dentistry is not an exact science and there is no guarantee of specific results. For the best results, it is imperative that I work together with the dental care team. This means that I will strive to keep all appointments and arrive on time. Cooperation and participation is imperative for the desired outcome.

I understand the dental care team will recommend procedures. The dental team will do their best to make sure I understand their care and plan. If I do not understand any of the treatment or the plan, I will discuss it with the dental team. I understand if I do not fulfill my part of the agreement by following their advices, I will be hampering the outcome of my treatment.

I understand that should I feel there are changes in my condition or symptoms appear between scheduled visits, I should notify the office immediately.

Signature of Patient: _____

Signature of Dental Care Team Representative: _____

INFORMED REFUSAL SAMPLE FORM

Dr. _____ has informed me of my dental condition and recommended the following treatment plan.

The benefits of this treatment included, but are not limited to:

The possible consequences and/or complications of not proceeding with the treatment include but are not limited to:

I understand complications to my oral and general health may occur if I do not proceed with the treatment recommended.

I have read or had this document read to me in its entirety. I have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it was presented. I understand the potential risks, complications and side effects. I have elected **not** to proceed with the recommended dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

I hereby assume all responsibility for my oral and general health condition and release Dr. _____ and his employees from any and all liabilities which may result from my refusal to consent to the treatment.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

ORAL SURGERY & EXTRACTIONS

Patient Name: _____

Date: _____

I hereby authorize Dr. _____ and his/her dental care team to perform the following procedure: _____ as a result of the diagnosis of _____.

Dr. _____ has explained to me the proposed treatment and the anticipated results of that treatment. I understand this is an elective procedure and there are other forms of treatment available, including the option of no treatment. The consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw and/or loss of bone. Impacted wisdom teeth are subject to and responsible for infections, cysts and tumors, cavities, pressure damage and periodontal damage to normal teeth and gums and bone.

Dr. _____ has explained to me there are certain risks in this treatment plan or the procedure he/she will be performing. These risks include but are not limited to:

- Injury to a nerve resulting in numbness, burning or tingling of the chin, lip, cheek, gum on the side on this the procedure in being performed as well as loss of taste in the case of the tongue. These nerve injuries can last for several weeks, months or in rare instances, be permanent.
- Drug and medication reactions, although rare, may occur. These reactions could include redness, swelling, pain, itching, vomiting and/or anaphylactic shock
- Postoperative infection accompanied by malaise or fever which may require immediate additional treatment
- Sinus involvement which would require additional surgery
- Muscle or jaw restriction of the mouth opening for several days or weeks as well as possible temporomandibular joint (TMJ) pain or dislocation
- Injury to adjacent teeth may occur which will require further dental care
- In rare circumstances breakage of the jaw, cardiac arrest or mortality
- Postoperatively discomfort, swelling, discoloration and bleeding may occur that may necessitate several days of recuperation at home
- A small piece of root tip left in the jaw would require extensive surgery
- Stretching of the corners of the mouth which may cause cracking and bruising
- Other _____

Unforeseen conditions may arise during the procedure that may require a different procedure than noted above. Therefore, I authorize Dr. _____ to perform such procedures when in his/her professional judgment, they are deemed necessary.

I understand it is my responsibility to contact the dental care team and seek immediate medical attention should any unusual circumstances present themselves postoperatively.

I voluntarily assume any and all probable risks, including but not limited to those situations addressed above which may be associated with any phase of the oral surgery care treatment plan. I shall diligently follow any preoperative instructions given to me. I understand the dental care team cannot make any promises or guarantees of the outcome or result.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with the dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature:

Patient Printed Name:

Date:

Doctor's Signature: _____

Date: _____

ORTHODONTIC TREATMENT

Patient Name: _____

Date: _____

You have the right and obligation to make decisions regarding your oral healthcare and that provided to you or your child. Your cooperation and participation in the decision making process is necessary. When undergoing orthodontic treatment there are certain risks and the potential for unsuccessful results. In order to minimize these outcomes, once treatment begins my complete cooperation and participation is necessary.

Appointments must be maintained as scheduled. Any delayed or missed appointments will prolong the treatment time and will inhibit the success of your plan. Instructions must be diligently followed with regard to oral hygiene and use of any adjunct appliances. The dental care team will instruct you on these issues; however, it is your responsibility to follow them as instructed.

Circumstances which are unforeseen at the start of the orthodontic treatment plan may occur. These include but are not limited to:

1. Decay, gum disease, decalcification (permanent markings on the teeth) may occur if the oral hygiene instructions are not followed properly. You will need to maintain checkups and dental care with your general dentist during the course of your orthodontic treatment plan.
2. Root canal therapy may be necessary to preserve a tooth when movement has revealed a non-vital tooth.
3. Temporal mandibular Joint Dysfunction (TMJ) can occur during the treatment. Should TMJ be exhibited, it will be necessary for the patient to see a TMJ specialist.
4. Root resorption may occur due to the application of force or movement of teeth back and forth as a result of prolonged orthodontic treatment. There are no long term consequences to root resorption unless there has been a greater than 50% loss of the root. In this case, stability of the teeth may be in jeopardy.

Once the orthodontic treatment has ended, there is the possibility of the teeth shifting. Retainers may be recommended by your dental care team along with instructions as to their use and care.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I understand the dental care team cannot make any promises or guarantees of the outcome or result. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Parent (or Legal Guardian) Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

SAMPLE

PEDIATRIC (CHILDREN'S) DENTISTRY

Patient Name: _____

Date: _____

You have the right and obligation to make decisions regarding your healthcare and the care provided to your child. Your cooperation and participation in the decision making process is necessary. When providing dental care to a child, special circumstances may arise.

1. **Preventing Injury:** The most difficult issue when treating children is controlling the child so that no injury accidentally occurs to the child as a result of an abrupt movement. In some cases, it might be recommended the child be sedated prior to the treatment. Additionally, various restraining devices may also be necessary to ensure the safety of the patient and the dental care team during treatment.
2. **Numbness in the tongue, lips, jaw and/or facial tissue** resulting from the administration of local anesthetic. Numbness may be present following treatment. During the period of time there is numbness, the child should be monitored and reminded not to bite or chew on the numb area and be careful drinking liquids. Any numbness which appears to last longer than 24 hours should be reported immediately to the dental care team.
3. **Below are some common occurrences in pediatric dentistry:**
 - **Cavities in children.** Because of the nature of deciduous (baby) teeth, coupled with difficulty in brushing and flossing regularly, cavities can occur very quickly. Special care is needed to avoid these problems. Preventative measures include fluoride treatments, placing sealants, thorough brushing, flossing, control of sweets and acids in the diet, coupled with regular dental checkups.
 - **Fractures and broken teeth.** Due to the fragility of the deciduous (baby), it can be difficult to secure large fillings in these teeth. If the child's tooth is unable to retain a filling or if the cavities are initially large, the dental care team may recommend the placement of crowns on the teeth in order to preserve them until the teeth fall out as a result of the maturity process.
 - **Pulpotomy** is a treatment where the pulp tissue in the upper part of the tooth is removed and replaced with various filling materials so the tooth is preserved, space is maintained as well as chewing ability until the permanent tooth replaces the deciduous tooth. The dental care team may recommend this procedure due to the thinness of the enamel of the deciduous tooth or rapid decay in the teeth. However, in spite of these efforts to save the tooth, extraction may still become necessary.
 - **Abscesses.** Deciduous (baby) teeth are particularly susceptible to abscesses. Abscesses can occur if the pulp tissue of the tooth has become infected. This is a very painful event with swelling. Abscesses can occur as a result of traumatic injury to a tooth as well. The office should be contacted immediately if you suspect an abscess.
 - **Extraction and space maintenance.** It may be impossible to save a tooth so the dental care team may recommend extraction. Maintenance of space is important for the permanent

teeth. Therefore, it may become necessary to insert an appliance known as a space maintainer. These devices can either be fixed or removable.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I understand dentistry is not an exact science and the dental care team cannot make any promises or guarantees of the outcome or result. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Parent (or Legal Guardian) Signature: _____
Date: _____

Doctor's Signature: _____
Date: _____

Witness Signature: _____
Date: _____

SAMPLE

PERIODONTAL SURGERY

Patient Name: _____

Date: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing Periodontal Surgery, treatment involving the gum and tissue supporting the teeth, there are certain risks and the potential for unsuccessful results. In order to minimize these outcomes, once treatment begins complete cooperation and participation is necessary to include follow up care.

After careful examination, the existence of periodontal disease has been noted. The progression of the disease has been explained to me which can include bone loss, eventual tooth loss and possibly other associated diseases such as heart disease.

Risks associated with treatment included but are not limited to the following:

- Future extraction of the teeth involved if the healing process is not achieved
- Sensitivity and soreness post operatively to hot and cold sensations, and sweet or sour foods
- Bleeding of the gums during or after treatment
- Recession of the gums which might increase sensitivity, create aesthetic or cosmetic changes or widening of the tooth spaces which can cause food to be trapped
- Broken instruments during the procedure may require surgical intervention
- Postoperative infection which may require immediate additional treatment
- Soreness/cracking in the corners of the mouth
- Mobility of the teeth where bone loss has occurred

The risks of not having this treatment as recommended include but are not limited to:

- Pain
- Bleeding
- Swelling
- Mouth odor
- Tooth mobility and/or tooth loss
- Infection which could lead to other health issues

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

ROOT CANAL THERAPY

Patient Name: _____

Date: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing root canal treatment there are certain risks and the potential for unsuccessful results.

Root canal treatment is also called endodontic treatment. Endodontic treatment involves removing the nerve and other tissues (known as pulp) from inside the tooth and from the roots. This is accomplished by creating an opening through the enamel of the tooth to gain access to the pulp. The pulp is removed and the canals where it is located are cleaned and shaped. The canals are then filled and sealed. Following a root canal, the tooth may need a final restoration such as a crown to function properly.

Root canal treatment can be necessary due to pain, infection, decay, a broken tooth or teeth or other condition. The benefit of the treatment will be relief of current symptoms and the continuance of any additional recommended treatment which may permit the tooth to be restored to its proper function

Alternatives to endodontic treatment depend on my diagnosis; however the most common alternatives are:

- Extraction of the tooth/teeth
- Extraction followed by an implant and crown
- Extraction followed by a bridge or partial denture
- No treatment which could worsen the condition leading to severe pain and swelling, infection which could be fatal, loss of the tooth/teeth

Root canal treatment, like all dental care has risks. The most common risks associated with this treatment include but are not limited to:

- Swelling and discomfort postoperatively
- Bleeding and postoperative infection accompanied by malaise or fever which may require immediate additional treatment
- Injury to a nerve resulting in numbness, burning or tingling of the chin, lip, cheek, gum on the side on this the procedure in being performed as well as loss of taste in the case of the tongue. These nerve injuries can last for several weeks, months or in rare instances, be permanent.
- Drug and medication reactions, although rare, may occur. These reactions could include redness, swelling, pain, itching, vomiting and/or anaphylactic shock
- Breaking of the canal instrument which may require further treatment and decrease the success of the procedure
- Sinus involvement which would require additional surgery

Once root canal treatment has started, it is imperative the treatment be completed. Additional appointments may be required.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

SAMPLE

SAMPLE DISMISSAL LETTER

Send certified mail with a returned receipt and regular mail

Date

Insert Patient Name

Insert Patient Address

Insert Patient City, State, Zip

Dear (Patient):

Thank you for selecting (dental group) as your dental care provider. It has become apparent because of a breakdown in our doctor-patient relationship, which is necessary for optimal care; your dental needs would be better met elsewhere.

This letter is to inform you that as of the date of this letter, I (we) will no longer be able to provide you your dental care and treatment. Should an emergency arise within the next 30 days, I(we) will be available to you during our regular office hours.

Dental conditions tend to worsen with time if they are not addressed. Therefore, I recommend you seek another dental care provider as soon as possible. Both the local and state dental associations can assist you with recommending a new dental care provider.

My office will be happy to forward your records to your new dental care provider upon receipt of a written release. Your new provider can help you with this release.

I appreciate the opportunity to have been of service to you as your dental care provider and wish you the best of luck moving forward.

Sincerely,

Doctor's Signature