John Beck, DDS (914) 693-4033
DobbsFerryFamilyDental.com
450 Broadway Dobbs Ferry, NY 10522

Name: _____

REQUEST & CONSENT FOR DENTAL TREATMENT

1. I request and authorize treatment by Dr. Beck and/or his associates.

2. I further request and authorize the taking of oral dental x-rays as necessary for diagnostic purposes and the use of dental anesthetic to treat my dental problem(s) if indicated.

3. Dr. Beck and/or his associates have explained to me and I have had sufficient opportunity to discuss my dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from my treatment plan, compared with alternative approaches and/or no treatment.

4. The usual and most **common risks or complications** occurring from the planned dental treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporary or permanent numbness, and allergic reaction to materials used during the treatment.

5. I understand that during the course of my dental treatment, unexpected events may arise that may necessitate procedures in addition to or different from those listed on the treatment plan, and that **I will be informed prior to initiation of treatment or procedure**. I acknowledge that no guarantees have been made to me concerning the results of the dental treatment I will receive.

6. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

(over)

Dobbs Ferry Family Dental
DFFD
Practicing All Phases of Advanced Dental Care

7. I confirm that I have read (or had read to me) and understand this consent and that my questions have been answered prior to signing below.

_____	_____
Signature of Patient/Parent or Legal Guardian	Date
_____	_____
John Beck, DDS	Date
_____	_____
Staff Witness	Date