CONSENT TO TREATMENT FORM

Patient Full Name: _____
Date of Birth: _____
Address: _____
Contact Number: _____

1. Purpose of this Form

This form confirms that you understand the nature, risks, and alternatives of the dental treatment you are agreeing to receive at Viva Dentistry.

2. Your Rights

- You have the right to ask questions at any time.
- You may request more information before deciding.
- You may withdraw consent at any time before treatment starts.

3. Treatment Information

- I have been advised of the recommended treatment, its purpose, and expected benefits.
- I understand the possible risks, side effects, and complications.
- I am aware of alternative options (including doing nothing) and their potential outcomes.
- I have disclosed my full medical history, including allergies, medications, and existing health conditions.

4. Consent

- I consent to the recommended treatment by the dentist or their delegated staff.
- I give permission for photographs/x-rays to be taken for diagnostic and record-keeping purposes.
- I understand that dentistry is not an exact science and results cannot be guaranteed.

Patient/Guardian Signature: _____
Date: _____

Dentist Signature: _____
Date: _____