

PATIENT CONSENT FOR DENTAL IMPLANTS

Patient Name	:	Alston Rebello	Emirates ID	:	111-1111-1111111-1
File No	:	17	DOB	:	1996-06-20
Gender	:	Male	Doctor's Name	:	Alan Alfred
			Date	:	2023-12-23

This form will acknowledge your consent to treatment recommended by your Dental Implantologist

1. I authorize Alan Alfred to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.




I authorize placement of implants in the areas of teeth s

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications which have been explained to me.
3. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications include the very rare potential of risks or complications, such as damage to vital organs including the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.
4. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.
5. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. You have the right to refuse or discontinue treatment. You will be informed about the consequence of your decision to refuse or discontinue treatment and about available care and the treatment alternatives.

I understand that ALL medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

In the event I wish to discontinue the treatment, I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall health may be affected by my decision.

I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in my overall health stemming from this condition.

Sign here, only if all of your questions have been answered to your satisfaction		
PATIENT	WITNESS	DOCTOR
		
If Guardian, relation to the Patient s	Witness Name ss Witness Names	Alan - Dental (GD10001) 2023-12-23