FREE SAMPLE DOCUMENT — Dental Clinic In A Box™ | Patient Consent Series

General Treatment Consent Form

RCDSO Compliant — Informed Consent Standard of Practice — Ontario Dental Practices

CLINIC INFORMATION

Clinic Name:		**Dentist Name:**	
Address:		**RCDSO Registration No:**	
Phone:		**Email:**	

PATIENT INFORMATION

Patient Full Name:		**Date of Birth:**	
Health Card No.:		**Chart Number:**	
Phone Number:		**Date of Consent:**	

PROPOSED TREATMENT

Treatment / Procedure:	
Tooth / Area of Mouth:	
Treating Provider:	

INFORMED CONSENT — PLEASE READ CAREFULLY

1. Nature of Treatment	I understand the nature of the proposed dental treatment, procedure, or service as described above and as explained to me by my treating dentist. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
2. Risks and Complications	I understand that all dental procedures carry some degree of risk. I have been informed of the potential risks, complications, and side effects associated with the proposed treatment, including but not limited to: pain, swelling, bleeding, infection, nerve sensitivity, tooth fracture, adverse reaction to anesthesia, and the possibility that the treatment may not achieve the desired outcome.

3. Alternatives to Treatment	I understand that alternative treatments may exist and that I have the right to choose among all reasonable treatment options, including the option of no treatment. The risks of declining treatment have been explained to me.
4. No Guarantee of Results	I understand that dentistry is not an exact science and that no guarantee or warranty has been made to me regarding the outcome of the proposed treatment. Individual healing and treatment outcomes may vary.
5. Anesthesia	If local anesthesia is required, I consent to its administration. I understand the risks associated with anesthesia including temporary numbness, bruising at the injection site, and in rare cases, prolonged numbness or nerve sensitivity.
6. Photographs and Records	I consent to the taking of clinical photographs, radiographs, and other records necessary for my dental care. I understand these records are maintained in my patient file in accordance with RCDSO recordkeeping standards and Ontario privacy legislation (PHIPA).
7. Billing and Insurance	I understand that I am responsible for payment for services rendered. My dental benefits plan, if applicable, is between myself and my insurer. Any amount not covered by my insurance plan remains my personal responsibility.
8. Right to Withdraw Consent	I understand that I have the right to withdraw this consent at any time prior to or during the procedure. If I choose to withdraw consent, I understand that the dentist may need to stop treatment.

PATIENT DECLARATION & SIGNATURE

By signing below, I confirm that: (1) I have read and understood this consent form, (2) the proposed treatment, its risks, benefits, and alternatives have been explained to me in a language I understand, (3) I have had the opportunity to ask questions and am satisfied with the answers provided, (4) I freely and voluntarily consent to the proposed treatment, and (5) I am capable of making this decision.

Patient Signature:		**Date:**	
Print Name:		**Witness:**	

If patient is under 18 years of age or incapable of providing consent:

Guardian / SDM Signature:		**Relationship to Patient:**	
Print Name:		**Date:**	

DENTIST SIGN-OFF

I confirm that I have explained the nature of the proposed treatment, its risks, benefits, and alternatives to the patient (and/or substitute decision-maker) in a manner appropriate to their level of understanding. To the best of my knowledge the patient (or SDM) understands and freely consents to the treatment described.

Dentist Signature:		**Date:**	

Print Name:		**RCDSO Reg. No.:**	

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