

EAST BRUNSWICK ORAL IMPLANT CENTER
Gary R. Dornfeld, D.D.S., P.A. & Associates
334 Milltown Road
East Brunswick, New Jersey 08816
(732) 238-6660

CONSENT TO TREATMENT

Patient Name: _____ Date: _____

CONSENT:

This informed consent and authorization is given to Dr. _____ after having first received a full explanation of the proposed treatment, alternative treatment and treatment risks. Based upon my symptoms and the full examination I have received, I have been advised that I have the following condition:

TREATMENT:

I hereby authorize and consent to the following procedure(s):

ALTERNATIVE TREATMENT:

I have been advised that alternate treatment exists, which may include but is not limited to:

I have, however, elected to treat my condition by the proposed treatment rather than any alternative treatment.

TREATMENT RISKS:

I understand that inherent to any procedure, and because of an individual's variations, certain risks are involved with this treatment. They may include, but are not limited to:

ADDITIONAL COMMENTS:

By signing below, I acknowledge that I have read this document, understand the information presented, and have had all my questions answered satisfactorily.

Patient: _____ Date: _____
(Or Person Authorized To Consent For Patient)

Doctor: _____ Date: _____

Witness: _____ Date: _____