

Patient Treatment Request

Please illustrate and answer ALL questions below pertaining to the treatment as recommended.

I hereby request the following doctor to render treatment as I have illustrated and answered below:

Doctor's Name

1. I hereby request treatment for the purpose of:

2. I understand should I not have treatment, the following may occur:

MAXILLA: _____
 MANDIBLE: _____

3. I understand the following treatments may be utilized as an alternative for my condition:

MAXILLA: _____
 MANDIBLE: _____

4. I understand the treatment for my dental condition will be by the following procedure:

MAXILLA: _____
 MANDIBLE: _____

5. I understand the proposed treatment has the following benefits over the alternative procedures:

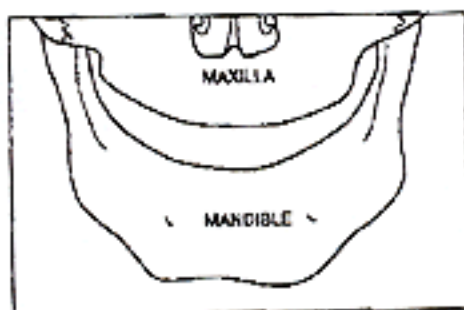
MAXILLA: _____
 MANDIBLE: _____

6. I understand the proposed results of the treatment are as follows:

MAXILLA: _____
 MANDIBLE: _____

7. I understand, as in the case of ALL surgical treatment, there is a risk factor. The risks have been explained to my satisfaction and they are as follows:

Please illustrate and describe the corresponding recommended treatment



Signature of Patient or Guardian

Date

Signature of Witness

Date

Signature of Dentist

Date