# Consent Form

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| **Dentist Details** | |
| **Name** |  |
| **Address** |  |
| **Qualifications** |  |

|  |  |
| --- | --- |
| **Patient Details** | |
| **Name** |  |
| **Address** |  |
| **Date of birth** |  |

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| --- |
| **Proposed treatment** |
|  |
| **Risks and Benefits** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cost of treatment** | **NHS** | **Private** | **Total** |
|  | **£** | **£** | **£** |

|  |  |
| --- | --- |
| **Dentist**  I confirm that I have explained to the patient/patient guardian the reason for the above treatment. I have outlined the risks of the treatment and have obtained a full medical history. I have also discussed with the patient the method of pain control which will be employed as part of the treatment. | |
| **Signature**  **Date** |  |

|  |  |
| --- | --- |
| **Patient/Patient guardian** *[delete as appropriate]*  I consent to undergo/I consent for *[patient name]* to undergo the treatment described above. I confirm that the reason for the above treatment has been explained to me and that I have been offered the opportunity to ask questions about the treatment. If any changes are required to the treatment, my specific consent will be obtained. | |
| **Signature**  **Date** |  |

|  |  |
| --- | --- |
| **Agreed changes to treatment plan (complete and date if need arises)** | |
|  | |
| **Dentist** | |
| **Signature**  **Date** |  |
| **Patient/ Patient guardian (delete as appropriate)** | |
| **Signature**  **Date** |  |

**Refer to GDC Standards Guidance ‘Principles of Consent’**