MIRA PEYYETI DDS PC

Patient Name: ______________________________ Date: __________

Treatment recommendations: ______________________________

The benefit of recommended treatment: ______________________________

Risks and possible complications: ______________

Approximate duration of treatment phases: ______________________________

Estimated cost of treatment: ______________________________

Alternate treatment recommendations: ______________________________

Risks and possible complications (of alternative treatment): ______________________

(Patient Name) I have reviewed and discussed the recommended treatments and alternative treatment recommendations with Dr. ____________. I understand that no dental treatment is risk free, the risks have been explained to me and that the dentist will take reasonable steps to limit any complications. Dr. [ ] has answered my questions about my treatment.

I have provided an accurate and complete medical history including medications I am taking and any known allergies.

I wish to proceed with the treatment recommendations.

Signed Patient______________________________ Date ______________________

Signed Dentist____

Signed Witness____