

Patient's Name: _____ Date: _____

I, (print name) _____, hereby authorize Dr. Chahine at
Dental Wellness and Health to perform the following treatment

The nature and the purpose of the procedure have been explained to me in a language which I understand, and I have voluntarily accepted the treatment.

Alternative treatment plans have been fully explained to me along with possible outcomes and risks.

I acknowledge there has been no "guarantee" as to results or long-term prognosis.

I understand that it is my responsibility to follow postoperative instructions and take medications as prescribed. Failure to do so may alter or harm the outcome of the proposed treatment.

I have been given ample time to discuss the procedure with Dr. Chahine and have had all of my questions and concerns answered to my satisfaction.

Patient's Signature (Or Guardian if a Minor)

Doctor's Signature

Witness's Signature

Date