Dynamic DENTISTRY
Current, Comprehensive & Comfortable

Procedural Consent Form

Dr. Christopher T. Reynolds

1. **Procedure:**

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2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language):

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_____

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_____

This procedure will be performed by **Dr. Christopher T. Reynolds**

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the above-named dental facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the above-named dental facility.

5. Exceptions to surgery or anesthesia, if any are:

   _____

6. I request the disposal by authorities of the above-named dental facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:
   a. The name of the patient and his/her family is not used to identify said pictures.
   b. Said pictures will be used only for purposes for medical/dental study or research.

Cross out any parts above which are not appropriate

8. COUNSELING DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

Signature of Counseling Physician/Dentist:

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9. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Signature of Witness, excluding members of operating team:

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Signature of Patient/Sponsor/Legal Guardian:

_____

Date and Time:

_____