



ADVANTAGE DENTAL

## CONSENT FOR DENTAL TREATMENT

You are entitled to a copy of this Consent for Dental Treatment.

I hereby authorize Dr. Paul M. Jiral and / or any such associate or assistant at Advantage Dental as may be selected and supervised by Dr. Jiral to provide me with dental treatment.

The nature, purpose and procedures of the proposed dental treatment have been explained to me and I understand them.

The risks, benefits, and possible complications of the proposed treatment, including the risk that such treatment may not accomplish the desired objective, have been fully explained to me.

Should complications occur, I understand that other procedures may be necessary.

I have been advised of the advantages and disadvantages of possible alternative treatments and my prognosis, if no treatment is received. Any questions I have had regarding the nature, purpose and procedures of the proposed dental treatment have been answered to my satisfaction.

I have had the opportunity to read this form, ask questions and have had my questions answered to my satisfaction. I hereby consent to the proposed dental treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is being signed by a personal representative of the patient, provide the following information (Please Print).

Personal Representative's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



ADVANTAGE DENTAL

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