

## CONSENT FOR DENTAL TREATMENT

Patient: \_\_\_\_\_

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

I hereby authorize Dr. Smith and Dr. Marlowe and his staff at 3365 S. Holmes Ave Idaho Falls, ID 83404 to perform upon the named patient the following procedures: exams, cleanings, or treatment as needed.

I understand that during the course of the procedures, unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedures which Dr. Smith or Dr. Marlowe may consider necessary.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedures.

I confirm that I have read and fully understand the above. I hereby consent to the proposed dental treatment.

\_\_\_\_\_  
signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter (if used)

\_\_\_\_\_  
Date