Plaza DENTAL CLINIC

Family Dental Practice since 1995
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T8V 6Z1

Dr. Inder Dhir
Dr. Vamsi Boddeda

www.plazadentalclinic.ca

CONSENT FOR DENTAL PROCEDURE AND CONSCIOUS IV SEDATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

I CONSENT TO THE FOLLOWING TREATMENT OF DENTAL REHABLITATION AND OR DENTAL EXTRACTIONS UNDER CONSCIOUS SEDATION BY Dr. Vamsi Boddeda at Plaza Dental Clinic

I ACKNOWLEDGE THAT **NO GUARANTEES** HAVE BEEN MADE TO ME AS TO THE RESULTS OF THE TREATMENT. I UNDERSTAND THE RISKS AND BENEFITS AND ALTERNATIVES, IF ANY, OF THE TREATMENT. I CONSENT TO THE ADMINISTRATION OF ANESTHESIA BY INTRAVENOUS SEDATION USING THE ANESTHETIC AGENTS, TECHNIQUES AND TREATMENTS AS MAY BE DEEMED ADVISABLE BY Dr. Vamsi Boddeda

HAS THE TREATMENT PLAN / SEDATION PROCEDURE AND PRE/POST OPERATIVE INSTRUCTIONS BEEN DISCUSSED WITH YOU?

YES / NO PREFORMED BY: _____ SIGNATURE: _____
(PRINT DOCTOR / STAFF NAME) (DOCTOR / STAFF)

I CERTIFY THAT I HAVE READ & UNDERSTAND THE ABOVE INFORMATION

PRINT NAME OF PATIENT: _____

SIGNATURE OF PATIENT (or GUARDIAN): _____

RELATIONSHIP TO PATIENT: _____

PRINT NAME OF WITNESS: _____

SIGNATURE OF WITNESS: _____

DATED THIS _____DAY OF _____20____