Greenwoods™ Dental & Surgical Centres

★ **693 McPhillips Street, Winnipeg, Manitoba R2X 2H6** **(204) 774-7774** **Fax (204) 633-1143**

249½ Henderson Highway, Winnipeg, Manitoba R2L 1M3 (204) 775-7775 Fax (204) 667-6229

246 Portage Avenue, Winnipeg, Manitoba R3C 0B1 (204) 779-7779 Fax (204) 594-5768

1531 Pembina Highway, Winnipeg, Manitoba R3T 2E5 (204) 221-2221 Fax (204) 504-5111

1462 Regent Avenue West, Winnipeg, Manitoba R2C 3A8 COMING SOON

1128 Richards Street, Vancouver, BC V6B 3E6 (604) 566-7666 Fax (604) 566-7660

First Name _____ Last Name _____ Date of Birth _____

It has been recommended that I have the following treatment : _____

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration. The treatment is necessary because of:

☐ Pain ☐ Infection ☐ Periodontal (gum) disease ☐ Decay ☐ Broken tooth / teeth

☐ Other : _____

The intended benefit of this treatment is : _____

RISKS OF RECOMMENDED TREATMENT

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. **These include:**

_____

ACKNOWLEDGMENT

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and posttreatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I realise that in-spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of the procedure.

I have received information about the proposed treatment. I have discussed my treatment with Dr._____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

Specialty Treatment Acknowledgement (if applicable) :
I understand that this procedure can also be performed by _____ (a dental specialist). I understand the risks and elect to have this procedure performed by Dr._____.

I understand that if any unexpected difficulties occur during treatment, I may be referred to for further care.

_____ _____
PATIENT / GUARDIAN SIGNATURE DATE

_____ _____
TREATING DENTIST SIGNATURE DATE