

# Total Dental Care

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## Patient Consent Form

*I have been informed about the condition of my teeth and discussed a treatment plan recommend by the doctor. I am aware of the risk and consequences of the treatment.*

*I have been advised of the risks and consequences, should I deny this treatment.*

*I understand that I may refuse to participate in this treatment and that if I refuse to participate; I am responsible of outcome of the choices that I make. I agree to participate in this treatment.*

*I realize that in spite of the possible complications and risks, my contemplated treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantee have been made to me concerning the results of this treatment.*

*I have filled out a medical history form, which lets the doctor aware of my allergies, medications, drugs, and the special diet that I am consuming. It is my responsibility to fill out the medical history form truthfully and to the best of my knowledge.*

*I have the opportunity to ask questions and receive answers for all teeth pertaining conditions. I have contemplated my dental condition, the recommend treatment and procedure, and the risk and complications, prior signing this form.*

*I have read this consent form. I have discussed with Dr. Kwonil Park or his staff the information in this consent form. I have been given the opportunity to ask questions and my questions were answered to my satisfaction.*

*I hereby authorize Dr. Kwonil Park and whomever he may designate as his assistant to perform the following treatment or procedure.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

I have fully explained to the patient the purpose, procedures and risks that are involved in the above-described study. I have answered all questions to the best of my ability.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature