Roya Arbab DDS

Patient Name_____ Date_____

Additional Specific Risks:

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I certify that I have read and understand this **INFORMED CONSENT** which outlines the general treatment considerations as well as the potential problems and complications of restorative/prosthodontic treatment. I understand that potential complications and problems may include, but are not limited, to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and the risks, as well as the potential consequences should I elect to postpone or refuse treatment. I understand that during and following treatment, conditions may arise that warrant additional or alternative treatment. I further understand that no guarantees can be made for a successful result.

Recognizing the potential problems and risks of restorative/prosthodontic treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. In addition, I grant permission for photographs taken by Dr. Roya Arbab, or photographs released from other healthcare practitioners, of the procedures to be publicized for teaching purposes only.

Signed_____ Date_____

Witness_____ Date_____

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