

# Informed Patient Consent Form

General Dental Treatment — IDA Format Reference

Customisable Template | Governed by Indian Contract Act & Consumer Protection Act 2019

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

Father/Spouse Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact No.: \_\_\_\_\_ Email: \_\_\_\_\_

Medical Conditions (if any): \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

## PROPOSED TREATMENT

Procedure / Treatment Recommended: \_\_\_\_\_

## INFORMED CONSENT DECLARATION

**1. Understanding of Treatment:** I confirm that the nature, purpose, risks, benefits, and alternatives of the proposed dental treatment have been explained to me in a language I understand.

**2. Risks Acknowledged:** I understand that dental treatment involves certain inherent risks including but not limited to: pain, swelling, infection, bleeding, nerve injury, incomplete treatment, allergic reactions to medications/materials, and TMJ issues. I accept these possibilities.

**3. No Guarantee:** I understand that dentistry is not an exact science and no guarantee of results has been made. Results may vary based on my medical condition, cooperation, and other factors.

**4. Emergency Situations:** I authorize the treating dentist to perform any additional procedures deemed medically necessary during treatment if an unforeseen emergency arises.

**5. Medical History Accuracy:** I confirm that all medical history, medication details, and allergy information provided by me is accurate and complete to the best of my knowledge. I will inform the dentist of any changes.

**6. Financial Responsibility:** I understand the approximate cost of treatment (Rs. \_\_\_\_\_) and accept financial responsibility for the same. I have been informed that costs may vary if additional treatment is required.

**7. Photography/Records:** I consent to clinical photographs being taken for medical records and educational/academic purposes, subject to my identity being protected.

**8. Minor Patient:** If the patient is a minor (under 18 years), this consent is given by the parent/legal guardian on their behalf. Name of guardian: \_\_\_\_\_

**9. Voluntary Consent:** I am signing this form voluntarily, without pressure or coercion, and in full possession of my mental faculties.

**10. Right to Refuse/Withdraw:** I understand I have the right to refuse or withdraw consent at any point, understanding the medical consequences of doing so.

# SIGNATURES

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Treating Dentist Name:** \_\_\_\_\_ **Reg. No.:** \_\_\_\_\_

**Dentist Signature & Stamp:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Name & Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Note: This consent form should be signed BEFORE treatment begins. Retain a copy in the patient record. Adapted from IDA recommended format ([ida.org.in](http://ida.org.in)). Consult a legal advisor for jurisdiction-specific modifications.*