

**K STREET DENTAL & ORTHO GROUP
3 WASHINGTON CIRCLE, NW #306
WASHINGTON, DC 20037
TEL: 202-775-0167**

SURGICAL CONSENT FORM

I hereby authorize Dr. _____
to perform upon (patient) _____,
the following treatment:

I have been informed the risks (bleeding,bruising,swelling,pain,
Infection ...) and side effects of such treatment as well as other
possible alternative methods of treatment.

I have been offered the available anxiety control techniques (N2O,
conscious sedation, oral sedation).

I have been informed in case of use of sedation I should not drive
or operate dangerous machinery.

I certify that I have fully read and understand the above consent to
surgery, and I had the opportunity to ask questions about the
operation.

_____ Date: _____
Patient's Signature

Witness: _____