Consent for Treatment

I consent to dental examinations, diagnostic procedures (including X-rays), and dental treatment deemed necessary by the dentist or authorized staff of Woodstock Family Dental. I authorize the dental team to use their professional judgment to make appropriate clinical and medical decisions as needed to support my dental health and overall care, including modifications to treatment if conditions are discovered during treatment.

I understand that dentistry involves inherent risks, including but not limited to pain, infection, swelling, bleeding, nerve injury, allergic reactions, or the need for additional or alternative treatment. I acknowledge that no guarantee or assurance has been made regarding the outcome or results of any dental treatment or procedure.

Signature: _____
Date: ____ / ____ / _____