

**Jeff Strachan, D.D.S.
Beeren Gajjar, D.D.S.
189 Montague Street Suite 800A
Brooklyn, NY 11201**

PERMISSION FOR DENTAL PROCEDURE(S)

1. I hereby authorize Dr Strachan/ Dr.Gajjar, to perform upon me or the named patient the following procedure(s).....

Print Name.....
Date

2. The doctor has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known to unknown causes), attendant discomfort and risks that may arise, as well as possible alternatives to the proposed treatment. The attendant risks of no treatment also have been discussed. I have been given the opportunity to ask questions, and all my questions have been fully answered and satisfactorily.

Relationship (If signed by person other than patient)

Interpreter (If used):

Signature.....

Print Name.....

Date

3. I understand that during the course of procedure(s), unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore consent to the performance of additional procedure(s), which the above named dentist may consider necessary.

The signature to the patient must be obtained unless the patient is an unanticipated minor (Under the age of 18) or is otherwise incompetent to sign.

Dentist Certification:

4. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s)

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the purposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

5. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing.

Patient/Relative or Guardian:

Dentist's Signature.....

Signature.....

Date

Date

Jeff Strachan, D.D.S.
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