Dr. Theresa Conway
290 Hilderbrand Drive • Suite A-9 • Sandy Springs, GA 30328 • Fax 404-255-0923
404-255-2273

Patient Consent Form

Pt Name: _____ Date of Scheduled Tx: _____

Treatment to be completed includes as follow:

_____

_____

_____

_____

I have been fully informed of the nature of the surgery, the procedure to be utilized, the risks and benefits of surgery as well as the alternative treatments available and the necessity of follow-up(s) and self care. I have had the opportunity to discuss any concerns that I may have in connection with the treatment recommended by Dr. Conway. After thorough deliberation, I hereby consent to the performance of the surgery as presented to me during my consultation and in the treatment plan as described in this document. I also consent to the performance of such additional or alternative procedures which may be deemed necessary in the best judgment of Dr. Conway.

I certify that I have read and fully understand this document and have received the following informed consent(s):

___ Extraction	___ Periodontal Surgery	___ Gingivectomy
___ Implant	___ Ginigval Augmentation	___ Biopsy
___ Explant	___ Frenectomy	___ Nitrous Oxide
___ Bone Regenerative Procedure	___ Apicoectomy	___ Oral Sedation
___ Sinus Augmentation/Lift	___ Crown Lengthening	___ Valium

_____

DATE SIGNATURE OF PATIENT/GUARDINAN

_____

DATE SIGNATURE OF WITNESSS

_____

DATE SIGNATURE OF DOCTOR