PATIENT: ______________________________
DATE: ______________________________

PARTIAL DENTURE REPAIR INFORMED CONSENT

You have been informed that you require repair or replacement to the following teeth or part of denture:

UPPER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	LOWER LEFT

PURPOSE OF THE TREATMENT:

This procedure is deemed necessary because:
❒ Need to replace or add teeth to present partial denture
❒ Present Partial is Broken, Unsuitable, Ill-fitting, Old, Unsightly etc.
❒ Other ______________________

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment.

I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material. I have been given the opportunity to ask questions.

I consent to the taking of photographs throughout the entire treatment procedure. Should these photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE ______________________

LAB FEE (approx.) ______________________

TOTAL FEE (approx.) ______________________

Dated at London, Ontario, this day of ______________________

SIGNED: ______________________
PATIENT

WITNESS: SIGNED: ______________________
Parent, Guardian or Nearest Kin if patient is under the age of 18