LIBERTY DENTAL PLAN

INFORMED CONSENT FOR DENTAL TREATMENT

Provider Office

Provider Name:						**Office ID#:**	
Address:						**Office Phone:**	
City:		**State:**		**Zip:**		**Office Fax:**	

Member

Member Name:						**Member ID#:**	
Address:						**Date of Birth:**	
City:		**State:**		**Zip:**		**Phone:**	

Type of Dental Procedure				
Tooth/Area	**CDT Code**	**Procedure Description**	**Accept**	**Decline**
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

As the dentist, I have explained to the member, his/her treatment, risks and benefits, and costs associated with the dental treatment/ procedure. **Signature is required.**

Provider Name

Provider Signature

Date

The dentist explained the nature of the treatment and how it will help me. I understand the risk and complications if I do not follow the instructions given to me after the procedure which involves post-treatment and follow-ups. **Signature is required.**

Member Name

Member Signature

Date