SPARKS
DENTAL
CENTRE

AP-732,'G'Block,2nd Street,11th Main Road,
Anna Nagar West,Chennai - 600 040,
Ph.: 044 - 4212 3262 / 2626 8026,
Email : sparksdentalcentre@gmail.com,
Web : www.sparksdental.in

CONSENT FORM

NAME :

D.O.B.:

SEX :

ADDRESS : **OCCUPATION :**

PHONE : **E-MAIL :**

Do you have any of these medical problems?

Heart Disease	Yes/No
Breathing Disease / Asthma	Yes/No
Allergies to Medicines (Penicillin Allergy etc)	Yes/No
Diabetes	Yes/No
Jaundice	Yes/No
Hormonal problems (Eg.Thyroid etc.)	Yes/No
Have you had any operations in past? If Yes, please give details	Yes/No
Are you taking medicines for any other problems? If Yes,please give the name & dodsage	Yes/No

For Lady Patients :

Are you Pregnant	Yes/No

AUTHORIZATION FOR TREATMENT

I hereby give my consent to administer any treatment / anaesthesia and to perform such procedures / operations as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks and possible consequences of the treatment proposed.

Date :

Patient's Signature