Informed Consent

_____ I the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below.

_____I understand the dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions. I will discuss the treatment options with the doctor that I am seen by.

_____I understand the risks inherent in the treatment(s). I have discussed these risk with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

_____I have disclosed my health history information, including allergies, reactions to medication, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

_____I authorize the undersigned provider and any qualified assistant or medical professional to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

_____I give my consent for the administration of any medication that may be required as a life-saving measure.

_____I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment.

_____I authorize the undersigned provider to take diagnostic x-rays, provide a comprehensive/periodic exam, cleaning, and fluoride treatment.

_____I authorize the undersigned provide to administer local anesthetic as needed for treatment.

_____I authorize the undersigned provider to place pit and fissure sealants.

_____One person (Parent/Legal Guardian) is allowed in the treatment room with the patient.
_____ I understand that I can't take pictures or videos of doctors performing any work/treatment when I go in the back office.

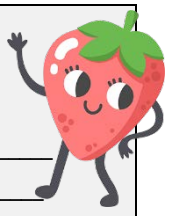
Patient Name (PRINT) _____ Date_____

Parent/Guardian Signature _____ Date_____

Doctor's Signature_____Date_____

Witness Signature_____Date_____

Health History & Informed Consent 6 Month Review



I certify that I have read and updated my child's health history. To the best of my knowledge, my child's health history remains the same.

I certify that I have reviewed and updated this Informed Consent.

Parent Guardian's Signature:_____ Date:_____

Dentist's Signature: _____ Date:_____

Witness Signature:_____ Date :_____