CONSENT FORM

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 (Name of Patient

hereby give consent to the above named doctor and dental auxiliaries working under the doctor’s supervision to perform whatever routine dental procedures on (myself, son, daughter, ward) they see fit. This can include the administration of a local anesthetic, taking radiographs, the rendering of emergency care, and prophylactic antibiotics as needed.

 I hereby certify that I have read and fully understand this Consent Form, the reasons why the intended treatment is considered necessary, its advantages, possible risks and complications, as well as possible alternative modes of treatment which were explained to me.

 I have been given the opportunity to ask questions and have received answers to my questions.

 I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of this treatment.

DATED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of person

 authorized to sign for patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness