CONSENT FORM

Date:	Office:	Patient:

I authorize Professional Dental and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Professional Dental at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially and legally. I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if prescribed treatment is not rendered within the reasonable prescribed amount of time.

I accept Professional Dental Consent Form:

Signature	Full Name	Relation to patient	Date