INFORMED CONSENT FOR DENTAL TREATMENT

I, (Print Name) ______________________________ authorize Dr. Scott Thompson and/or assistants to perform the following procedures:

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This includes the administration of anesthetic, analgesia, or other medication or pharmaceutical agent that may be necessary.

I understand that dentistry is not an exact science and success cannot be guaranteed. The dental treatment that is necessary to treat my existing condition(s) has been explained to me and I have had the opportunity to have my questions satisfactorily.

I voluntarily assume any or all possible risks that may be associated with any of these procedures. I understand it is my responsibility to diligently follow the instructions given to me in regard to my treatment.

I have provided as accurate and complete a medical and personal history as possible, including medical history and conditions, antibiotics, drugs or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me.

____ _____________________
Patient's Signature or Guardian if patient is a minor Date

____ _____________________
Witness Date

____ _____________________
Dentist Date