

INFORMED CONSENT FOR TREATMENT

I authorize Matthews Dental and their Doctor's, associates, Hygienists 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 untoward reaction or side effect, which may include but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures, and basic dentistry, teeth may remain sensitive or even possibly painful during and/or after treatment.

I do voluntarily assume any an all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventatives and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for 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 hereby do abide by the conditions outlined herein.

Patient/Guardian Signature

Date _____