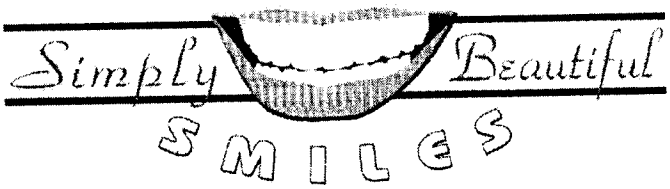

Simply Beautiful Smiles of Medford

Request and Permission for Dental Treatment

Patient name_____
Please print

Legal Guardian (If patient is under 18 years of age) _____
Please print

I hereby authorize the dentist and staff at Medford Dental Associates to treat me or the person under my care (I am the legal guardian).

I understand that during the course of treatment, complications may arise, which could necessitate additional or alternative procedures. Such complications can include, but are not limited to, the need for root canal or extraction.

I understand that there may be multiple options to treatment, all with associated risks and benefits. I further understand there may be consequences associated with refusing treatment.

I consent to the use of local anesthetics ("Novocain"), antibiotics and analgesics (pain medication), and understand there may be potential risks associated with their use or the use of any drug. These risks include allergic reaction, aspiration pain, cardiac arrest, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs. Injury to nerves during local anesthetic injection is rare, but may lead to "numbness" that lingers beyond the usual period of time.

I consent to the use of nitrous oxide analgesia, if I so desire. I understand that there are risks and benefits of its use.

I confirm that I have read and fully understand all of the information provided above.

Patient/Legal Guardian Signature:_____Date_____