

CONSENT TO PROCEED

I authorize Dr. Gary Foster and/or any such associate, hygenist, or assistant as he may designate to take radio-graphs, study models, photographs, or utilize any other diagnostic aids deemed appropriate by Dr. Foster or his designee to make a diagnosis of my dental needs.

I authorize Dr. Gary Foster and/or such associates, hygenists, or assistants as s/he 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 of side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk 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.

Signature _____
(Patient, legal guardian, or authorized agent of patient)

Date _____

Witness _____

Date _____