

CONSENT TO PROCEED

PATIENT'S NAME _____.

I authorize Dr. Joseph Johnson / Landon Rockwell and /or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health of any minor or other individual for which I have responsibility, including arrangement and/or any 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 effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risk, 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: _____ Date: _____.
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____.