MORTENSON Family Dental

Consent for Treatment

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I permit the recommended diagnostic procedures, to be completed.

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of treatment.

I consent to the injection and administration of local anesthetics. I understand that there is an element of risk with the injection of any injectable agent. These risks include, but are not limited to: adverse drug reactions, allergic reactions, cardiac arrest (heart stops beating), tachycardia (very fast heart beat), swelling, bruising, pain, transient or permanent nerve damage (numb lip, etc.), asthmatic reactions (difficulty breathing), needle tract infection and other unspecified injuries.

I wish to proceed with treatment

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Patient's Parent or Guardian	Parent or Guardian Signature	Date

I refused to proceed with treatment

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Patient's Parent or Guardian	Parent or Guardian Signature	Date