

General Consent for Treatment

Patient

Date

I hereby authorize and request the performance of dental services for the above-named patient by Dr. Lizette M Dreyer or staff and further authorize the performance of whatever procedure Dr. L Dreyer may deem necessary during the performance of any treatment. These procedures include, but are not limited to: examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

I further consent to the taking of photographs, films or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education, or the showing to the public at large.

I do hereby authorize and request Dr. Lizette M Dreyer to perform dental oral surgery and carryout whatever procedures she deems necessary during surgery, after alternatives have been explained to me.

I know the practice of dentistry is not an exact science and therefore, no guarantee or assurance has been given by anyone as to the result that may be obtained.

Patient

Date

Relationship to patient