STACY KIRNER FELIX DMD, INC.

CONSENT FOR DENTAL TREATMENT

I herby authorize the doctor, or designed staff, to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me.

I agree to the use of anesthetics, sedatives and other medication deemed necessary. I fully understand that using anesthetic agents embodies certain risks for complications. This may include (but not limited to) pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the vein), reaction to injections, change to occlusion (biting), muscle cramps, and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by alcohol or drugs), thus it is advisable not to operate any vehicle, hazardous device, or work for 24 hours until recovered from their effects.

I understand that during treatment it may be necessary to change some or all procedures due to conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes to the treatment as deemed necessary.

I further understand the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene, and dietary instructions, and reporting to the office any change in my health status as soon as possible.

SIGNATURE____ DATE__________________________

Relationship to Patient: Self Parent Guardian

Print Name____