W. Stuart Dexter, D.D.S., L.L.C.

7301 Mission Road, Suite 206
Prairie Village, KS 66208-3031
O: (913) 362-8200 F: (913) 362-8270

CONSENT FOR DENTAL TREATMENT

Patient's Name: _____ Date of Birth ___/___/_____

I hereby authorize the doctor or designated staff to take radiographic images, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, antibiotics, analgesics, or any other medication that may be deemed necessary in my case. I understand there is a slight risk inherent in the administration of any drug or anesthesia. This risk includes possible adverse drug reactions such as allergic reactions. I am aware that I can ask for a complete recital of any possible complications.

I have provided as accurate and complete dental health history as possible, including antibiotics, drugs, medications, metals, and foods to which I may be allergic. I will follow any and all instructions as explained and directed to me.

I have had the opportunity to discuss proposed treatment with the doctor, to ask questions, and receive answers and explanations for these questions. I have also had the opportunity to be aware of alternative treatment and procedures, and their potential benefits and risks.

This is to certify that the proposed dental treatment, alternatives, and risks have been explained to me and all questions that I have asked have been fully answered to my satisfaction.

Patient or Guardian's Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____ Date: _____