HEALTH QUESTIONAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Greenwood and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or 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, are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative 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 treatment have been explained to me and I have been given the opportunity to ask questions.

Signature: ___________________Date: _______
(patient, legal guardian or authorized agent of patient)

Witness: _____________________Date: _______