**Authorization to Treat Patient**

1. **After being informed** I hereby authorize and direct the dentist(s) of Noll Family Dentistry and or/dental auxiliaries to perform the following dental treatment, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
2. Preventive hygiene treatment (teeth cleaning) and the application of topical fluoride.
3. Application of “sealants” to the grooves of the teeth.
4. Treatment of diseased or injured teeth with restorations of composite (white filling), amalgam(silver filling) or crown.
5. Replacement of missing teeth with fixed permanent dental bridges, partial dentures, or full dentures.
6. Removal (extraction) of one or more teeth.
7. Treatment of diseased or injured oral tissue (hard or soft) \*Periodontal disease
8. Treatment of crooked teeth and/or development or growth abnormalities.
9. I understand that there are risks involved in any dental treatment and hereby acknowledge that these risks will be explained to me and will have the opportunity to ask questions regarding the treatment so that I fully understand.
10. I agree to the use of local anesthesia, nitrous oxide analgesia (laughing gas) when applicable. I understand that the use of nitrous oxide gas may cause dizziness and nausea. I understand and have been informed of any risks or complications.
11. **After being informed**, I therefore authorize and request performance of any additional dental procedures that are deemed necessary or desirable to oral health and well-being in the professional judgement of the treating dentist.
12. I recognize that during the course of treatment unforeseen circumstances may arise and therefore necessitate additional or different procedures from those discussed. After consultation, I authorize and request the performance of any additional procedures that are deemed necessary by the treating dentist for better oral health.
13. I will be advised that the success of the dental treatment to be provided will require that the patient and/or guardian/parents follow all post care instructions. I agree that the success of the treatment requires that all instructions be followed and regular dental visits be maintained.
14. I hereby state that I have read and understand this consent and that any questions about the dental procedures will be answered to the best professional knowledge of the treating dentist and/or dental auxiliaries.
15. I **have the right to be provided answers to questions that may arise during the course and after dental treatment.**
16. **I further understand that this consent will remain in effect until such time I choose to terminate it.**

Patient’s Name: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applicable)

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient or parent or guardian

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Office use

witness