Consent to Proceed

I authorize Dr. Jason May and/or such associates or assistants as 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 administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other 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, but are not limited to bruising, hematoma, cardiac stimulation; muscle soreness; and temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled unto the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscope or other procedures to ensure safe removal.

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 treatment 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 excepting those risks that might arise out of negligence on the part of Dr. Jason May and or such associates or assistants as he may designate for performed procedures. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name_____

Responsible Party (if other than patient)_____

Signature of Patient or Responsible Party_____Date_____

Witness_____Date_____

Notice of Privacy Practices

I acknowledge that I viewed a copy of Watertree Dental Care Notice of Privacy Practices.

Patient Name_____

Responsible Party (if other than patient)_____

Signature of Patient or Responsible Party_____Date_____