



HEALTH QUESTIONNAIRE ACKNOWLEDGMENT 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. Larsen and /or such associates or assistants 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. This includes 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 treatment.

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, and temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

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. 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.

SIGNATURE: _____
Patient or Legal Guardian

DATE: _____

WITNESS: _____

DATE: _____