PATIENT'S NAME _____

Last First Initial Date of Birth

I hereby authorize Monty B. Buck, DDS and whomever he may designate as his assistants, to perform upon me the following operation and/or procedures:

See attached treatment plan.

I request and authorize him to do whatever he deems advisable if any unforeseen condition arises in the course of these designated operations or procedures calling in their judgment, for procedures in addition to or different from those now completed.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and consequences if this treatment is withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary to my case, and understand that there is an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response, allergic reactions, cardiac arrest, and aspiration, irritation and swelling, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain possible complications including post operative bleeding, swelling, bruising, discomfort, stiff jaws, loss or loosening of dental restorations, infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure, and swallowing or aspiration of teeth and restorations and small root fragments remaining in the jaw which may require extensive surgery for removal.

❑ I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

❑ Any controversy arising out of this contract or any modification or extension thereof, including any claim for damages or sescission, or both, shall first be submitted to mediation in accordance with the code of ethics published by the Society of Professionals in Dispute Resolutions, between the conflicting parties. Each party agrees to schedule the mediation within one month of the matter being referred to a mediator, and each party agrees to attend the mediation for a period of at least one hour. If the parties cannot agree on a mediator, the mediation shall be conducted at Settlement Consultants International, Inc. (a Texas Corporation), by a mediator chosen by Settlement Consultants International in accordance with the code of ethics published by the Society of Professionals in Dispute Resolutions. Each party agrees to share equally in the cost of the mediation attempt. If the mediation does not result in an agreement or does not result in a complete agreement, AND the mediator declares that a dispute as to the facts of the case exists and that the dispute as to the facts is a material basis for the parties' failure to reach agreement, then the parties shall immediately submit the unresolved dispute(s) to arbitration. If a party refuses to mediate or arbitrate, then that party may not recover attorneys' fees or costs in litigation brought to construe, enforce or rescind this agreement.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

❑ I have had the opportunity to ask questions and receive answers to, and responsive explanations for, all questions about my medical condition, contemplated and alternative treatments and procedures prior to signing this form.

Patient or Guardian's Signature _____ ***Date*** _____

Dentist's Signature _____ ***Date*** _____

Witness' Signature _____ ***Date*** _____

CONSENT FORM