CONSENT FORM

Patient's Name: _____Date:_____

I hereby authorize Gregory P. Martin, D.D.S., P.C. and his assistants in charge of my care.

I consent to the recommended treatment after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment was withheld.

I further consent to the administration of local anesthesia or any other drug that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response such as allergic reaction, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

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.

I realize that it is mandatory that I give as accurate medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

_____

Signature of Patient Date

_____

Signature of Parent or Guardian Date

_____

Signature of Witness Date