Newhouse PERIODONTICS
IMPLANT DENTISTRY | REGENERATION

CONSENT TO DIAGNOSIS, TREATMENT, SURGERY, AND/OR THE ADMINISTRATION OF ANESTHESIA

Patient: _____ Type of Procedure: _____

Date: _____ Time: _____ AM_____ PM _____

I, the undersigned, have requested that you perform diagnosis, treatment, surgery, and/or administer anesthesia on myself.

I do hereby give Dr. N. L. Newhouse full and unconditional authority to proceed with diagnosis, treatment, surgery, and/or the administration of anesthesia as your judgment may indicate. Further, if in the course of the contemplated operation or treatment, a different or more extensive operation or treatment, in your judgment, is required you are fully authorized to proceed therewith.

The undersigned is obligated and bound to hold you and/or your associates harmless from any and all consequences for such diagnosis, treatment, surgery, and/or the administration of anesthesia, provided that your duties are performed to ordinary standards of care and to the best of your ability. If these standards have been met, you and each of your associates are hereby fully released from any and all claims and demands whatsoever which might arise, grow out of, or be incident to such diagnosis, treatment, surgery, and/or the administration of anesthesia.

I am aware of the fact and fully understand that no medical or dental procedure is without risks, possible alternative methods of treatment, or the possibility of complications. I also hereby agree that I will not permit any work to be done until such time as reasonable explanations of the risks, possible alternative methods of treatment and possible complications are made to my satisfaction. I also clearly understand that such explanations may not or need be totally or fully comprehensive, depending upon my wishes.

I also agree that presentation of myself to this office for any diagnosis, treatment, surgery, and/or the administration of anesthesia shall constitute full and unconditionally binding agreement to all of the terms of this consent form.

I further acknowledge and agree that no guarantee of assurance has been or will be made as to any possible results that may be obtained.

I certify that I have read and fully understand the above consent form, that any necessary explanations of this form have been made to me, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

Signed: _____ Date: _____
(Patient or person authorized to consent for patient)

Witness: _____