



Dental Consent

1. I hereby authorized **Kathy Jacobsen, D.M.D.** and her team to perform the following dental treatment including the use of any necessary local anesthesia, x-rays, or diagnostic aids. All treatment was explained to me prior to initiation of treatment.
 - A. Preventive hygiene treatment, (prophylaxis), application of topical fluoride and application of sealants.
 - B. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
 - C. Extraction of one or more teeth.
2. I understand that there are risks involved in this treatment and herby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional of different procedures from those discussed. Dr. Jacobsen will stop and explain any deviation from original treatment plan.
5. I understand that failure to proceed with treatment can lead to adverse effects.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and publication. Likeness may be used in our books or website.

I have read and understand the material read.

Print Name: _____

Signature: _____ Date: _____

Parent or Guardian if minor: _____