



John R. Anderson, DDS

1401 North 1075 W #200
Farmington, UT 84037
801-447-KIDS (5437)

3485 West 4800 South
Roy, UT 84067
801-774-KIDS (5437)

Patient's Name _____

CONSENT TO PROCEED: I authorize Dr. John R. Anderson, DDS and/or such associates or assistants as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including 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 treatments. 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 do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive 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. Protective restraints are used when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. 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: _____ Date: _____
(Patient, legal guardian, or authorized agent of patient)

Witness: _____ Date: _____