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| **GENERAL DENTISTRY**  **INFORMED CONSENT** |

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the Highlands Dental Care. These procedures include, but are not limited to; examinations, X-rays, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

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(print your name) (relationship) (date)

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(your signature) (witness) (date)