Cameron G. Francis D.D.S.
2410 W. University Dr.
McKinney, TX 75071
(972) 562-0228

HEALTH QUESTIONAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change in medical health, conditions, or medications can effect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Cameron G. Francis and/or such associates or assistants as he may designate to perform those procedures as may be deemed 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 other administration of any sedative (including nitrous oxide), analgesic, 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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

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 preventative and operative 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. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given opportunity to ask questions.

Signature: _____ Date:_____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____