H. Talbott Tebay D.D.S and Associates
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SURGICAL CONSENT FOR OPERATIONS, ANESTHETICS, AND OTHER PROCEDURES.

PATIENT_____ DATE_____

1. I hereby request and authorize Dr. H. Talbott Tebay or Associate to perform the following procedure or procedures _____ deemed necessary to diagnose or treat my condition or conditions. If in the preparation for, during, or following the procedure contemplated above, other conditions are discovered which in the best judgment of the Doctor, make a change or an extension of the originally intended procedures necessary to advisable, I authorize and request that the above named Doctor, and his assistants perform such extended or revised procedure or procedures.
2. THE NATURE AND PURPOSE OF THE OPERATION AND PROCEDURES STATED IN PARAGRAPH ONE ABOVE, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, THE RISKS INVOLVED, AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN EXPLAINED TO MY SATISFACTIONS BY MY DENTIST.
3. I have also been informed that in the performance of any surgical or operative procedures there are risks such as from loss of blood, blood transfusion infection, cardiac arrest, nerve damage, and others. I am aware that the practice of dentistry and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I recognize that it is my responsibility to disclose to my dentist any physical or emotional condition and medication recently taken which may be detrimental in any way to the success of the procedure or to my ultimate recovery.
4. I consent to the administration of such anesthetics as may be considered necessary or advisable by the dentist responsible for this service.

WITNESS SIGNATURE OF PATIENT

If patient is unable to sign or is a minor, complete the following:
Patient is a minor, _____ years of age or is unable to sign because _____.

WITNESS LEGAL GUARDIAN