CONSENT FOR TREATMENT BY STEPHEN C. NOBLE, D.D.S. AND STAFF

This is my consent for Dr. Stephen C. Noble, DDS, and any auxiliary employed by him to perform the dentistry indicated on my personal chart, and any other procedure deemed necessary in the course of treatment. I also agree to the use of local anesthesia, radiographs (x-rays) and diagnostic aids. I understand that the practice of dentistry, like all aspects of healthcare, can encounter circumstances which cannot be predicted because of the uniqueness of individuals. I understand that if I have withheld any information or not answered accurately the document known as "Health History', I may place myself into a compromised situation which can result in serious harm or even death.

Complication/Risk

I understand that occasionally there are complications from dental treatment and local anesthesia including, but not limited to: pain, infection, swelling, bleeding, facial discoloration, nausea, vomiting, bruises, numbness (temporary or permanent), nerve injury, tingling of the lip, tongue, chin, gums or cheeks and, in EXTREMELY RARE cases, even death.

I understand that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow the post-operative and post-care instructions from the dentist. I agree that the success of dental treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be kept.

I understand that not all services provided by this office are necessarily covered by dental or medical insurance. I understand that I am ultimately financially responsible for all treatment and that any amount paid by my insurance will be applied to my account to decrease the amount that I owe. I hereby accept the treatment plan and authorize release of information hereto-related to my insurance company, benefit provider or specialist to whom I may be referred. I certify the truth of all personal information given. I have read (or have had read to me) the above consent and I fully understand what I am signing. I further understand that this consent will remain in effect until such time that I may choose to terminate it.

I authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.

Other Specific Risks:_____

Date:_____ Time:_____AM/PM

Name of Patient:_____

If Patient is a Minor, Name of Parent or Guardian:_____Relationship:_____

Signature of Patient/Parent/Guardian:_____Witness:_____