
PATIENT NUMBER

© 2001 Wisconsin Dental Association
(800) 243-4675

PATIENT'S NAME _____

Last

First

Initial

Date of Birth _____

I hereby authorize _____

Doctor's Name

and whom ever he/she may designate as his/her assistants, to administer me the following anesthetic:

I am informed as to the nature of this anesthetic, the way it will be administered and understand its usual effects. I have been informed of the advantages and disadvantages of the anesthetic. I have been told that the risk and potential complications inherent in its administration are:

The dentist has informed me of alternative anesthetics their advantages, disadvantages, risks and potential complications.

I realize that in spite of the possible complications, the use of anesthetics is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the use of anesthetics.

I am allergic to the following antibiotics, drugs, medications and foods:

I have provided as accurate and complete a medical and personal history as possible and will follow any and all instructions as explained to me and directed.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, and the risks and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature

Date

I personally have explained the above information to the patient or the patient's guardian.

Dentist's Signature

Date

Witness's Signature

Date

CONSENT TO ANESTHESIA