

LSU FACULTY DENTAL PRACTICE

CONSENT FOR TREATMENT

I hereby authorize the dental practitioners of LSU Faculty Dental Practice or personnel authorized by them to:

1. Perform those procedures necessary to complete treatment.
2. Perform treatment, procedures or tests differing from the original treatment plan that may arise from unforeseen conditions which the practitioner considers necessary or advisable during the course of treatment.
3. Obtain medical information and/ or reports from my medical doctor in order to facilitate my diagnosis and treatment.
4. Use local anesthesia, analgesia sedation and/ or general anesthesia.
5. Perform surgical procedures in or around the mouth.
6. Use and dispose of any tissue or parts which are removed.
7. Take and use photographs, materials, tissues and records pertinent to my case for the purposes of teaching, research and scientific publications.

I certify that I have read and fully understand the terms of the consent above.

Signature of Patient, Parent, or Guardian: _____

Witness: _____

Date: _____