Denver West Dental Group
14062 Denver West Pkwy. #52-120
Golden, CO 80401
303-279-5050
Fax 303-279-1685

Informed Treatment Consent

As the undersigned, I here by authorize the doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medications, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. The risk due to anesthetics, although uncommon, could include nausea, pain swelling, inflammation, and/or bruising at the injection site. Although rare, other risks could include: nerve damage, allergic reactions, heart attack, stroke, brain damage and/or death.

Patient Name (please print)

Signature (patient or responsible party) Date

Witness (office staff) Date