Smiles "R" Forever
Practice of Karl Rayan D.D.S.

CONSENT FOR ORAL/DENTAL EVALUTION AND RADIOGRAPHS

Patient: Date:_____

I hereby authorize **Dr. Karl O. Rayan** and associates at **Smiles "R" Forever** to perform upon me or the named patient, an oral/dental evaluation and any necessary radiographs. To my knowledge I have given the doctor an accurate report of my health history, including prior allergies, unusual reaction to drugs, food, anesthetics, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.

_____ _____
Signature of Patient or Guardian **Date**

CONSENT TO MEDICAL/DENTAL TREATMENT

- I hereby authorize **Dr. Karl O. Rayan,** and associates at **Smiles "R" Forever** to perform upon me, or the named patient, medical/dental services and the use of local anesthesia, as deemed necessary in my treatment.
- I have been carefully evaluated and the diagnosing doctor has fully explained to me the nature of my oral/dental problems and the purpose of the recommended procedure(s). I also have been informed of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks on my oral/dental health as a result of no treatment being opted have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
- I agree and understand that the degree of success of any dental treatment is directly related to my cooperation and maintenance of my oral/dental health. If I fail to comply or cooperate to recommendations, as instructed by the doctor and his staff, I may suffer injury to my oral health.
- I understand that during the course of the procedure(s), unforeseen conditions or complications may arise which necessitates procedures different from those contemplated. I, therefore, consent to the performance of additional procedure(s) which the above named-doctor and associates may consider necessary.
- I also agree to authorize photographs and other viewing of my treatment case during its progress to be used for the advantage of oral/dental health.
- I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).
- I confirm that I have read and fully understand the above and hereby consent to the proposed medical/dental treatment.

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Signature of Witness **Date**

_____ _____
Signature of Doctor **Date**