Dental Medical Stabilization Consent

Patient Name: _____DOB:_____

I HEREBY AUTHORIZE Dr. Keon Ahghar and Dr. Sarah Usher and whomever he/she may designate as his associates, to use stabilization and/or protective immobilization in the course of providing routine clinical dental treatment for above named patient.

Use of Medical Stabilization attached describing the reasons why this stabilization/sedation might be necessary, the expected benefits, possible alternatives and foreseeable risks of this approach.

I have had the chance to ask questions about the use of stabilization and/or sedation. Please contact us to discuss any concerns you may have at (575)622-4455. I understand the risks, the expected benefits and the possible consequences of lack of dental care for the above named patient.

I understand that my consent must be voluntary and that I may withdraw consent in the future.

Signed:_____Date:_____
(Legal Guardian)

Relationship to Patient:_____

_____

FOR OFFICE USE ONLY

Provider Signature:_____Date:_____

Witness Signature:_____Date:_____