Consent for Dental Treatment
James M. Stuart, DDS

This form serves to document that I authorize Dr. James Stuart and/or his staff to provide general dental care to me and/or my legal dependents. I understand this treatment may include the following:

- Taking radiographs (x-ray)
- Dental prophylaxis (cleaning) with hand instruments, ultrasonic instruments, and/or air polishers
- Topical fluoride application
- Administration of anesthetics
- Operative procedures (sealants, fillings, crowns/bridges, veneers)
- Surgical procedures (extractions, sutures)
- Prosthetic procedures (dentures, bleaching trays, bruxism/snore appliances
- Endodontic procedures (root canals)

I understand that the rationale for treatment, the risks associated with treatment, and options for other treatment(s) will be explained verbally to me by Dr. Stuart and/or his staff prior to care being rendered. I understand that if I have ***any*** questions regarding the nature or risks of treatment, I am encouraged to express them ***before*** treatment is initiated.

_____ _____

Signature Date

_____

Printed Name