

Health Questionnaire Acknowledgement & CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointments.

I authorize Dr. Stephen F. Johansen and/or assistants, as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporarily or rarely permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I request and consent to all dental procedures which my dental conditions or those of my dependants may require, and I understand that procedures in dental surgery, diagnosis, and treatment are not an exact science and no guarantees as to the outcome of my treatments will be offered only that Dr. Stephen F. Johansen will exercise his professional expertise and ability in my best interests according to his best judgment. In consenting to any oral surgery I understand that possible hazards may include, but are not limited to: pain, swelling, bruising, infection, tingling, or numbness of the lips, tongue, gums, and/or face, loss or damage to other teeth or restorations, root or tooth into the sinus, oral antral fistula, maxillary sinusitis, possible mandibular fracture, and postoperative hemorrhage and discomfort. Adverse reactions to materials, medicines, anesthetics, and procedures are possible in dentistry, possibly resulting in, but not limited to, pulpal irritation, root canal treatment, loss of teeth, necrosis, infection, pain, anaphylactic shock, and intestinal or systemic upset, and voluntarily assume the possible risks. I consent to the fees charges for services by Dr. Stephen F. Johansen and they are satisfactory to me. In essence, I accept Dr. Stephen F. Johansen as my dentist and understand that he will exercise all his professional knowledge to the best of his ability.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Signature (Parent or Legal Guardian) Date
I have reviewed my original health history above and certify that it is accurate except for changes indicated below:

Date	Changes	<input type="checkbox"/>	Patient Signature	Reviewed By
		None		
Date	Changes	<input type="checkbox"/>	Patient Signature	Reviewed By
		None		
Date	Changes	<input type="checkbox"/>	Patient Signature	Reviewed By
		None		
Date	Changes	<input type="checkbox"/>	Patient Signature	Reviewed By
		None		