Columbia Periodontal
ASSOCIATES
Periodontal and Implant Dentistry

William B. Farrar, DDS
Diplomate, American Board of Periodontology
J. Lee Ayers, Jr., DMD, MHS
Diplomate, American Board of Periodontology
Mark L. McEntire, DMD, MSD
Diplomate, American Board of Periodontology
Dustin C. Hedgpeth, DMD, MSD
Diplomate, American Board of Periodontology

CONSENT TO OPERATION, ANESTHETICS, AND OTHER DENTAL SERVICES

1. I authorize the performance upon _____
(myself or name of patient)
of dental procedures explained as necessary to treat indicated periodontal or dental concerns. This treatment is to be performed by Dr. Farrar, Dr. Ayers, Dr. McEntire, Dr. Hedgpeth and/or staff of Columbia Periodontal Associates.

2. I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the procedure.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the periodontist responsible for this service, with the exception of spinal or general anesthetics.

4. The nature, purpose, and benefits of the operation, possible alternative methods of treatment to include delay or refusal of surgery, the risks involved, the possible consequences, and the possibility of complications have been explained to me by Dr. Farrar, Dr. Ayers, Dr. McEntire, Dr. Hedgpeth and/or staff of Columbia Periodontal Associates.

5. I acknowledge that no guarantee or assurance has been given to anyone as to the results that may be obtained.

6. I consent to the photographing of the operations or procedures to be performed, for medical, scientific, or educational purposes.

7. For the purpose of advancing medical education, I consent to the admittance of observers to the operation room.

8. I understand that Columbia Periodontal Associates may ask for a blood draw for HIV/Hepatitis testing if an employee is injured by a needle stick or exposure to body fluids.

9. I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

Signed:_____
(Patient or person authorized to consent for patient)

Date:_____

_____
(Witness)

Date:_____

Updated 7/6/2015