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AUTHORIZATION AND INFORMED CONSENT FOR TREATMENT GENERAL

Patient _____

Legal Guardian _____

I hereby authorize Dr.(s) _____
to perform the treatment explained to me during my examination and consultation. I further authorize the
administration of medications and anesthetic.

It has been explained to me that during the course of my treatment, conditions may be revealed that
necessitate an extension or modification of the original procedure(s) or different procedure(s) from those set
forth. I therefore authorize the performance of such procedures as are necessary. When applicable, the
authority granted under this paragraph shall extend to treating all conditions that require treatment and are
not known at the time the treatment is commenced.

I am aware that the practice of dentistry, anesthesia, and medicine is not an exact science and I acknowledge
that no guarantees have been made to me concerning the results of any treatment.

I certify that I have read the above and that I understand its contents and consent fully and freely to
treatment. I further acknowledge that the dentist has explained to me foreseeable risks and consequences
associated specifically with my treatment as well as the reasonable benefits which may be expected from
such treatment. In addition, the dentist has explained to me the reasonable alternatives, if any, to the
proposed treatment and their risks. Further, I have been made aware of the potential risks in the adminis-
tration of anesthesia. These risks include, but are not limited to swelling, discomfort (pain), bruising,
hematoma, bleeding, and difficulty opening the jaw; nerve injury which may cause numbness, tingling,
bruising, or other abnormal feelings of the lips, chin, teeth, gums, and/or tongue, which may be temporary
or permanent; and inflammation of the vein (phlebitis) at the injection site.

Patient/Legal Guardian Signature _____ Date _____

Witness _____ Date _____

AFFIRMATION OF INFORMED CONSENT BY DENTIST

I affirm and certify that on this date I have informed the patient or legal guardian of the patient of the
treatment proposed and/or further diagnostic procedures. I have, consistent with my best medical judge-
ment, explained to the consenting party(ies) the nature and purpose of treatment and procedures, possible
alternative methods of treatment and procedures, and the risks, complications, and benefits of the treatment
and procedures.

Signature _____ Date _____