FAMILY, IMPLANT & COSMETIC
DENTISTRY
Fadi Raffoul, D.M.D. | Sanford Schwartz, D.D.S.
CREATING BEAUTIFUL SMILES SINCE 1979

CONSENT FOR PHOTOGRAPHS, CONSULTATION & LOCAL ANESTHETIC

I consent to photographs being taken of me. I understand that they may be used for education, documentation and illustration of my treatment.

_____ Yes _____ No, I refuse (initials)

I consent to having patients with similar treatment needs call me for consultation, to learn more about what they might expect with treatment.

_____ Yes _____ No, I refuse (initials)

I consent to use of my photographs and/or testimonials for marketing and/or web site.

_____ Yes _____ No, I refuse (initials)

I consent to the use of local anesthetic as necessary. Without anesthetic, I may experience pain and success of treatment may be compromised. I recognize the risks of anesthetic include, but are not limited to: palpitations or racing heart; chest pain; dizziness or fainting; anxiety reaction; allergic reaction or death; trismus (jaw stiffness or difficulty opening); pain; swelling; lip or cheek biting; infection; bleeding or bruising; injury to nerves to the eyelid, lip or tongue, causing numbness or altered sensation, which may be permanent.

_____ Yes _____ No, I refuse (initials)

_____ _____
Patient, Parent or Guardian Date

_____ _____
Doctor Witness