C. Thomas Fitts, III, DMD, FAGD, PA
4415 Hardscrabble Road
Columbia, S. C. 29229

Consent for Treatment

Please review the following consent and sign it prior to treatment, however, it does not commit you to the treatment. If you have any questions or if there is anything you do not understand, please ask the doctor.

This is my consent for the general dental procedure(s) indicated and any other procedure deemed necessary or advisable as a corollary to the planned therapy performed by the dentist(s) employed by C. Thomas Fitts, III, DMD,PA and any assistants with whom they work. I agree to the use of local anesthesia depending upon the judgment of the dentist. I understand the dentist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of general dental procedures and anesthesia may include swelling, bruising, pain, trismus (restricted jaw opening), bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which is rarely protracted and even more rarely is it permanent. I understand that it is my responsibility to report any symptoms to the dentist immediately.

I hereby give Dr. C. Thomas Fitts, III my consent for dental treatment.

I understand the above information.

Patient's Signature:______________________________Date:_______
(Guardian signature in case of minor)