CONSENT FORM FOR IMPLANT SURGERY AND ANESTHESIA Pg. 3

11) To my knowledge, I have given an accurate report of my health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I authorize Dr. Kitchin to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner he deems appropriate. However, no photographs or other records which identify me will be used without my express written consent.

12) I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.

13) I agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences that result from not following my dentist's advice.

14) Questions to ask Dr. Kitchin: ____

15) I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THAT THE ABOVE AUTHORIZATION AND INFORMED CONSENT TO IMPLANT PLACEMENT AND SURGERY AND THAT ALL MY QUESTIONS, IF ANY, HAVE BEEN FULLY ANSWERED. I HAVE HAD THE OPPORTUNITY TO TAKE THIS FORM HOME AND REVIEW IT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY INITIAL ON EACH PAGE ALONG WITH MY SIGNATURE BELOW WILL BE CONSIDERED CONCLUSIVE PROOF THAT I HAVE READ AND UNDERSTAND EVERYTHING CONTAINED IN THIS DOCUMENT AND I HAVE GIVEN MY CONSENT TO PROCEED WITH IMPLANT TREATMENT AND RELATED SURGERY, INCLUDING ANY ANCILLARY BONE GRAFTING PROCEDURES.

____________________________________ Dentist Signature

____________________________________ Patient Signature

____________________________________ Witness Signature

____________________________________ Witness Signature

____________________________________ Parent or Guardian, if Patient is a Minor

Date: ______________________

_______ Initial