

**MISC. PROCEDURES –  
INFORMED CONSENT TO TREATMENT**

I have been told that I require treatment on the following teeth:

UPPER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	LOWER LEFT

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment.

I have had the purpose, reasonable risks, benefits and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material and have been given copies. I have been given the opportunity to ask questions.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment. It is understood that I am unable to take the following medication:

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I understand that medications, drugs, and anaesthetics may cause drowsiness, incoordination, and an unawareness that may be compounded by the use of alcohol or other drugs. I have been advised, understand, and agree not to operate any vehicle, hazardous device, or machinery for at least twenty four (24) hours, or until fully recovered from the effects of the anaesthetic and/or medication that may have been administered or prescribed.

I consent to the taking of photographs throughout the entire treatment procedure. Should these photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE	
LAB FEE (approx.)	
TOTAL FEE (approx.)	

DATED at London, Ontario, on

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SIGNED:

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PATIENT

WITNESS:

SIGNED:

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Parent, Guardian or Nearest Kin if patient  
is under the age of 18