

DENTAL INFILTRATE CONSENT

I _____ understand that a Dental Infiltrate will be performed to provide temporary relief of discomfort associated with the administration of Resylane. I understand that Dental Infiltrates are not 100% effective but should reduce pain in most cases.

The risks of a Dental Infiltrate include bleeding, infection, and adverse reaction to the anesthetic.

_____(Initial) I do not have any hypersensitivity to any local anesthetic agents, nor do I have a history of malignant hyperthermia.

I have read and understand this consent and all of my questions have been addressed and answered to my satisfaction. I have no contraindicating factors, and thereby grant permission for a Dental Infiltrate. I certify that if any changes occur in my medical history/health or regime, that I will notify this office as soon as possible.

Client (Print Name)

(Signature) Date

Witness (Print Name)

(Signature) Date