

GENTLE FAMILY DENTISTRY & ORTHODONTICS

Sage L. White, DDS, FAGD, PC
747 S Paradise Canyon
Cedar City, UT 84720

PATIENT'S NAME _____

I authorize Dr. Sage White or such associates as he/she may designate/perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature _____ **Date** _____
(Patient, legal guardian or authorized agent of patient)

Witness _____ **Date** _____

MEDIATION AGREEMENT(optional): Should any claim or controversy arise between the patient and/or a legally authorized representative of the patient and dentist concerning the care and treatment rendered by the dentist or associates to the patient, and effort shall be made by the parties involved to resolve the dispute through mediation according to the rules of WESTERN MEDIATION, should the dispute pertain to the quality of the dental services rendered. Thus, a claim or controversy shall first be submitted to non-binding mediation. The parties involved shall share costs for the mediation services equally. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.

Signature _____ **Date** _____
(Patient, legal guardian or authorized agent of patient)

Witness _____ **Date** _____