AZ Dental Center
Dr. Zaliya Akbasheva
1619 Grant Ave, Suite 23
Philadelphia, PA 19115
215-673-4940

Authorization for Dental Treatment

I hereby authorize Dr. Zaliya Akbasheva and her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he or his associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance, or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s):_____

Tooth Number(s)_____

Date:_____

Dentist:_____

Patient Name (Print):_____

Legal Guardian/ Patient Signature:_____

Witness:_____