

**Magnolia City Dental**

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I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Magnolia City Dental. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam and composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reactions, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

\_\_\_\_\_  
Patient/Parent or Guardian Signature

\_\_\_\_\_  
Date