GENERAL CONSENT FORM

I _______________________________ do herby consent to routine dental treatment with Dr. Brian Hoops and his associates. I understand that Dr. Hoops, the hygienists, and the assistants that may treat me will use clinical and patient management techniques that are reasonable, necessary, and advisable. I authorize the administration of anesthetics or analgesics, with may be deemed advisable by Dr. Hoops for fillings, root canals, crowns, extractions, etc.

Patient Signature__________________________

Parent or Guardian if patient is a minor___________________________

Patient’s DOB________________ Date__________________