

**William Glover, III, DMD, LLC
Cosmetic & Implant Dentistry**

Patient's Name: _____ Date of Birth: _____
Last First MI.

I hereby authorize William, Glover, III, DMD, LLC and whomever he may designate as his assistants, to perform upon me the following procedures:

Oral exam and diagnostic x-rays

I request and authorize him to do whatever he deems advisable if any unforeseen condition arises in the course of these designated procedures calling in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above procedures.

I further consent to the administration of local anesthesia, antibiotics, analgesics or other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g., irritation and swelling of a vein), pain discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit prescribed diagnostic procedures.

Patient's or Guardian's Signature _____ Date _____

**1507 S. Hiawasse Rd, Suite 209, Orlando, FL 32835
407-522-5595 * facsimile 407-522-5598**