MORTIERE & GASPAROTTO, DDS
5958 NORTH CANTON CENTER ROAD
SUITE 600
CANTON, MICHIGAN 48187

PERMISSION TO RELEASE HEALTH HISTORY

I grant the right to the dentist to release health information obtained from me, and about my dental treatment to third party payors and/or other health practitioners.

Person completing the form: Signature_____

Print Name_____

Date_____

If other than patient, indicate relationship_____

PERMISSION TO ADMINISTER ANESTHETICS AND/OR ANALGESIA

I, _____on_____ do herby
Name Date
grant permission for administration of anesthetics and/or analgesia (Nitrous Oxide) and to employ such operative and technical procedures as are necessary or advisable for the diagnosis and treatment of my case.

_____ _____
Signature of Patient Signature of Parent or Guardian

_____
Signature of Dentist