

Maisa M. Idriss, D.M.D., P.A.
16215 Nth Freeway
Suite # 100
Houston, Texas 77090
281-444-0030



Consent for Radiographs

I hereby authorize Maisa M. Idriss and whomever she may designate as her assistant to perform upon me the following

**Procedures: 1. RADIOGRAPHS
2. TREATMENT AS PRESCRIBED**

I request and authorize Dr. Maisa Idriss to do what ever she deems advisable if any unforeseen condition arises in the course of these designated procedures calling, in there judgment, for procedures in addition to or different from those now contemplated

I consent to the above treatment after having been advised of the risks, advantages or disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs deemed necessary in my case. I understand that there is a sight element of risk inherent in the administration of any drug or anesthesia.

I realize in spite of the possible complications and risks, my treatment is necessary and desired by me. I am aware that the practice of Dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of my treatment

I have provided as accurate and complete a medical and personal history as possible including any and all medications or foods to which I'm allergic to. I will follow any and all instructions as explained and directed to me by Dr. Idriss and staff.

**Patient or Guardian
signature _____**

Date: _____