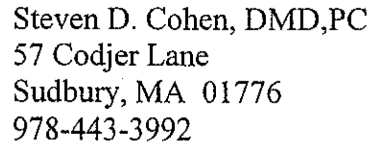

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AUTHORIZATION FOR DENTAL TREATMENT AND ANESTHESIA

I authorize and consent to the performing of the following procedures:
routine examinations, cleanings, fillings, radiographs
as needed and preventive health visits
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and authorize the use of local anesthesia as indicated. The risks of such procedure(s) have been explained and alternative treatment(s) fully described.

__________________________ ________________
Signature Date

____
Witness

Remarks: ____________________________________
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____
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____