ADVANCED
DENTISTRY
THE ART OF THE SMILE

Treatment Authorization

DATE ______________________________

PATIENT'S NAME ______________________

ADDRESS ____________________________

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I hereby grant authority to Advanced Dentistry, and/or the dentist(s) in charge of my care, to administer any treatment and such anesthetics as may be deemed necessary in the diagnosis and treatment of my case.

I acknowledge that I have been informed of possible risks and consequences of the proposed treatment and do authorize the above Doctor's to proceed.

PATIENT OR GUARDIAN'S SIGNATURE: ______________________________ DATE: ______________

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