GEMINI DENTAL

DENTAL TREATMENT AUTHORIZATION

I give my consent and authorization to GEMINI DENTAL to perform any dental treatment procedure or get anesthesia if needed for the diagnose and treatment that the doctor considers is needed. I understand that:

A: That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical- dental practice among members of the medical –dental profession with similar training and experience in this or similar medical communities: and from this information provided to me by my dentist, I, under these circumstances, have at least a general understanding of the procedures the medically, accepted alternate procedures or treatments and the substantial risk and hazard inherent in the proposed treatment or procedures wich are recognized among dentist in this or similar communities who perform similar treatment procedures.

OR

B: That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

________________________ Name of Patient

________________________ Date

________________________ Patient Signature