GEMINI
DENTAL TEAM

AUTHORIZATION FOR MEDICAL AND DENTAL TREATMENT

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as matter of law it shall be conclusively presumed:

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 this 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 which are recognized among dentist in this or similar communities who perform similar treatment procedures.

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

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