Consent for Treatment

I am ______________________________ and I authorize examination and treatment as necessary by or under the supervision of Dr. Arbogast. This includes exposure of radiographs as necessary, use of local anesthetic, and use of appropriate medicaments and materials for such treatment.

I have read and understand the above information and the information given to me verbally. By my signature below I consent to the treatment described in this paper.

Patient signature_________________________________Date________

Parent signature_________________________________Date_________

(If patient is a minor)

Witness ________________________________Date__________