AUTHORITY FOR TREATMENT

Patient's Name ____ Date ______________________

Address ____

I hereby grant authority to:

DEAN E. KENT, DDS, PC
CHARLES J. LAURENCE, DDS, PC
KEENAN M. DAVIS, DDS, PC
317 EDWIN DRIVE
VIRGINIA BEACH, VA 23462
757-499-2100

and/or to the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics; and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case.

In the event the doctor or a staff member is punctured by a sharp instrument, I agree to have my blood tested. I acknowledge that I have been informed of the risks and possible consequences of the treatment proposed and do authorize the above names doctor(s) to proceed.

Signature ____

Patient or nearest relative in the case when the patient is a minor or physically or mentally incompetent.