CONSENT
AND AUTHORIZATION

DENTAL AND/OR MEDICAL SERVICES

We appreciate the opportunity to serve you. It is our intent to provide you the finest care possible while insuring that you fully understand our procedures and treatment. To insure that your care comes first, we require your consent for Dr. Cynthia Haug, Dr. Michelle Orris, or Dr. Britt Bovio of Tioga Dental Associates to treat you under all circumstances while in this facility as follows:

The undersigned, on behalf of himself/herself, or minor (if applicable) hereby authorizes and consents to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment and/or transport to hospital care (if deemed necessary) to be rendered by Dr. Cynthia Haug and Associates of Tioga Dental, licensed dentists in the State of Florida.

I HEREBY CONFIRM, CONSENT, AND AGREE TO THE FOREGOING.

Date:_________ Signature of Patient ________________

IF THE PATIENT IS A MINOR, A SIGNATURE OF THE PARENT OR GUARDIAN IS REQUIRED.

Date:_________ Signature of Guardian______________
Parent, Guardian, or person having
Legal Custody of patient (if minor)