

**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 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 Tioga Dental Associates, 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 Guardian_____

**(Parent, Guardian, or person having
Legal Custody of patient (if minor)**