KENNEDY
NORTH DENTISTRY

12533, Kennedy Road, Caledon, L7C 2H1
Ph. : 905-872-6707
kennedymail125@gmail.com

1. I hereby authorize Dr._____ of Kennedy North Dentistry to carry out in the dental clinic the following procedure necessary to my dental treatment.

   _____

2. I have had explained to me, the purpose, reasonable risks, benefits of and alternatives, if any to the procedures recommended for my dental treatment services. Such questions have been answered to my satisfaction.

3. I consent to the administration of such local anesthesia as is required for the said dental treatment. I also certify that no guarantee has been made to the results that may be obtained.

4. I read and understand English – circle one Yes No

Dated at Caledon, Ontario, ____ day of ____ 20__

_____ _____
Signature Print Name

_____
Signature of Witness