Lake Merced Dentistry

General and Cosmetic Dentistry

Jiahua Zhu DDS

TREATMENT AUTHORIZATION

DATE _____

PATIENT'S NAME _____

ADDRESS _____

_____

_____

I hereby grant authority to Jiahua Zhu D.D.S., and or the dentist(s) in charge of my care, to administer treatment and such anesthetics as may be deemed necessary in the diagnosis and treatment of my case.

I acknowledge that I have been informed of possible risks and consequences of the proposed treatment and do authorize the above Doctor's to proceed.

Signed _____ **Date** _____

Patient, or guardian if the patient is a minor or if the patient is physically or mentally incapable. 1/13