☐ I refuse to give my consent for the passociated with this refusal.	proposed treatment(s) as described above and have been explained the potential o	consequences
Sign here, only	rif all of your questions have been answered to your satisfaction	
Aileen Raneses Dabolkar	Aprol.	14-03-2024
Patient's name	Signature of Patient Legally authorized Representative	Date
		14-03-2024
Witness Signature		Date
Beny		14-03-2024
Dentist's Signature	Dr. Neha Singh Specialist Endodontics DENTISTREE DHA-00234921-003 DENTISTREE DENTAL CLINIC	Date