authorize Dr. Neha Singh and / or his associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

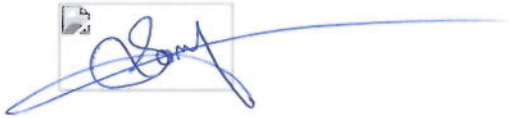
☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

Sign here, only if all of your questions have been answered to your satisfaction

Simran Popli Ram Chand Popli — 14-Mar-2024

Patient's name	Signature of Patient Legally authorized Representative	Date
		14-Mar-2024

Witness Signature	Date
	14-Mar-2024

Dentist's Signature	Date