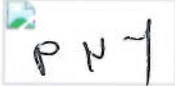
☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

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

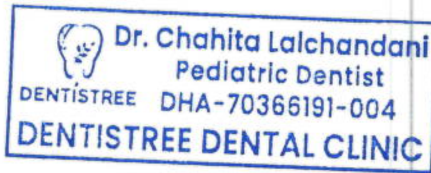
Pransh Nikunjkumar Yadav 04-05-2024

Patient's name **Signature of Patient Legally authorized Representative** **Date**



04-05-2024

Witness Signature **Date**



04-05-2024

Dentist's Signature **Date**