

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. *pt is being informed if Pain will happen after treatment- she will have to do re*

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

*isw # 31.*



Lara Samantha Kent

23-03-2024

**Patient's name**

**Signature of Patient Legally authorized Representative**

**Date**

23-03-2024

**Witness Signature**

**Date**

23-03-2024

**Dentist's Signature**

**Date**

*R. Rutul Desai*

