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**CONSENT FOR TREATMENT - ADULT**

I \_\_\_\_\_ consent to examination and treatment as necessary by or under the supervision of Drs. Edelman and or Stevenson. This includes exposure of radiographs as necessary, use of local anesthetics, and use of appropriate medicaments and materials for such treatment.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN TO ME VERBALLY. BY MY SIGNATURE I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_