Dan P. Hilton, D.D.S.
20969 Ventura Blvd., Suite 7
Woodland Hills, CA 91364
818-347-3971

Authorization for Dental and/or Surgical Treatment
INFORMED CONSENT

Date_____

I, the undersigned hereby authorize Dr. Hilton (and whomever he may designate as his assistants) to administer such treatment as is necessary to perform the following procedure(s)_____.

I further authorize any such additional operations and/or procedures as are considered therapeutically necessary on the basis of findings during the course of said operation and/or procedure(s). I also consent to the administration of such anesthetics as are necessary.

Any tissues or parts surgically removed may be disposed of in accordance with accustomed practice.

I hereby certify that I have read and fully understand the above authorization for dental and/or surgical treatment, the reasons why the above-named procedure or surgery is considered advisable, its advantages and possible risks and complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Hilton. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Signature of patient _____

Witness _____