EVONNE W. HWANG, D.D.S.

H & N DENTAL CARE, PLLC
39-10 MAIN STREET, SUITE 301
FLUSHING, NEW YORK 11354
TELEPHONE 718-939-8800

CONSENT FOR TREATMENT

I hereby authorize any treatment necessary as related to dental care for the patient whose name appears on this form. I grant authority to administer such anesthetics and analgesics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. Possible adverse effects or the procedures, anesthetics and/or drugs to be employed in this treatment have been explained to me and I have had the opportunity to ask questions.

Patient's Name：_____

Signature (Patient/ Guardian)：_____

Date：_____