The Wellness Center

2017 Central Avenue
Alameda, Ca 94501
Tel. No (510) 522-0878
Fax No. (510) 522-0894

TREATMENT AUTHORIZATION

Date ________________________

Patient's Name ____

Address ____

____

I hereby grant authority to Dr. Terecita L. Dean, D.D.S. to administer treatment and such anesthetics as may be deemed necessary in the diagnosis and treatment of my case.

I acknowledge that I have been informed of possible risks and consequences of the proposed treatment and do authorize the above doctor to proceed.

Signed ______________________________________ Date ___________
Patient, or Guardian if the patient is a minor or if the patient is physically or mentally incapable.