



FRANK D. VISINTINI, D.D.S., P.C.

7710 Fourth Avenue
Brooklyn, New York 11209
Telephone: (718) 748-1710

Patient Name _____
Date _____

Consent to Treatment

I hereby grant Dr. Frank Visintini and/or the Hygienist in charge of my care to administer any treatment, to administer required anesthetics, and to perform such operations as may be deemed necessary in the diagnosis and treatment of my care.

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

I also have been given every possible treatment option for my care including no treatment at all.

Signed this Day: _____
Witness: _____