TREATMENT AUTHORIZATION

I, _____, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my treatment in this office today.

COMPLAINTS

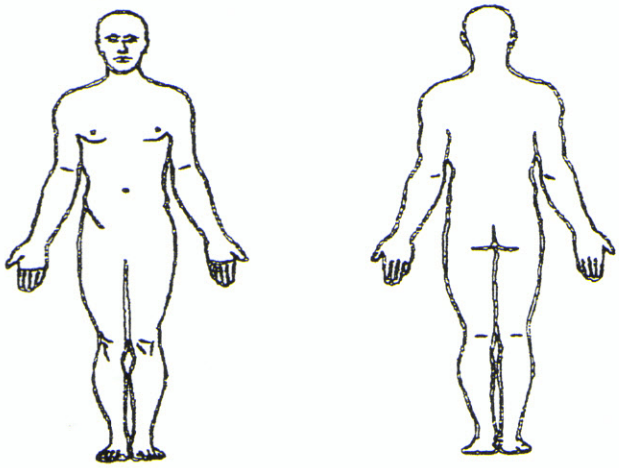
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

VISUAL PAIN INTENSITY SCALE

Zero (0) represents no pain and (10) represents the worst pain. (Please circle your pain level at the present time)

0 1 2 3 4 5 6 7 8 9 10

Shade or mark on the figure your area of pain



Date:_____

Patient's Signature: _____

Legal Guardian Signature:_____

Witness:_____