PEDIATRIC & ADOLESCENT
DENTISTRY

Consent

Since my child ____is a minor,
(Patient's full name)

It becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by the doctors at Pediatric and Adolescent Dentistry.

Authorization is hereby granted to do an examination, take x-rays, clean teeth, give fluoride treatment, and provide oral hygiene instructions if deemed necessary. Following a consultation, authorization is hereby granted to administer any treatment, anesthetics, extractions, and perform such operations or otherwise treat my child as it may be deemed necessary or advisable. I also give permission to provide my child with emergency care if needed.

I authorize my pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

I understand that I accept responsibility for payment of services rendered.

I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

Signed: ____Date:___________________
(Parent or legal guardian)