PDA
Pediatric Dental
ASSOCIATES
Board Certified Pediatric Dentists

CONSENT FOR EXAMINATION AND TREATMENT

I, _____, authorize the doctors and their dental staff to perform an oral examination, a dental prophylaxis (cleaning), and, if appropriate, topical fluoride application. Dental radiographs (x-rays) may be taken as necessary (in accordance with the guidelines established by the American Dental Association) to complete the diagnosis of my child's oral condition. If the dental treatment becomes necessary, I authorize the performance of necessary treatment, medication, and therapy that is indicated in connection with dental care of the listed minor patient(s) and authorize the doctors to choose and employ such techniques and assistance as deemed fit during treatment. I understand that I will have the right to be provided with answers to questions which may arise during the course of my child's diagnosis and treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in affect until such time that I choose to terminate it.

Furthermore, I will be responsible for financial obligations incurred on my child for dental treatment.

Patient name:_____ DOB:_____

Patient name:_____ DOB:_____

Patient name:_____ DOB:_____

Patient name:_____ DOB:_____

Parent/Guardian:_____ Date:_____