CONSENT FOR DENTAL TREATMENT

I request and authorize for my child's dental care. This includes an examination, cleaning and any necessary dental treatment. I further request and authorize the taking of dental x-rays, as may be considered necessary for the diagnosis and/or treatment of my child's dental concern. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children include efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The team at Great Beginnings Pediatric Dentistry will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Child's Name: ____ DOB: ________________

Parent/Guardian (please print): ___________________________ Relationship to Child: ___________

Signed: ____ Date: _________________