CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I hereby authorize the dental office to administer such medication and provide comprehensive oral rehabilitation. I understand that the treatment may include, but is not limited to the following: comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions.

I hereby certify that I am the legal guardian of the above referenced client or have otherwise been empowered to give consent on behalf of this client for dental treatment and extractions. This consent shall remain in force until unless otherwise terminated by me.

I have read the above, my questions have been answered, and I consent to Comprehensive Dental Treatment.

_____ _____/_____/_____

Name of Parent/Guardian (Please Print Full Name) Date

_____

Signature of Parent/Guardian

_____

Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

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