



Bearden Family Dentistry

Informed consent for under 18

Patient's Name: _____ Birthdate: _____

I give my permission for my child to receive dental treatment deemed necessary by the providers at Bearden Family Dentistry. These procedures include but are not limited to examinations, oral prophylaxes (cleanings), Fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns) periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, and changes in pain perception. This consent shall be considered in effect until rescinded or revoked.

Divorced Parents: We are not a party to your divorce decree, the parent who has legal custody will need to be present and sign. The parent accompanying the child is responsible for the payment we will not get in the middle of a financial disagreement between the parents. If it is court ordered that one parent is financially responsible that parent must sign a financial agreement. It is also the parent's responsibility to inform the office if there is a change to the child's dental insurance, please provide the front desk with a copy of that card.

The section below is to be completed by the parent or legal guardian ONLY.

I affirm I am the parent or legal guardian for the above-named child. If I am unable to accompany my child, I give permission for the individuals listed below to escort my child for dental treatment.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Since my child is under 18, I give my permission for him or her to present for treatment unaccompanied by an adult. I understand that no invasive treatment will be performed such as fillings, crowns, extractions, root canals unless I have been notified by phone, however in the case of an emergency and I am unable to be reached by phone I give my permission for what ever therapies are deemed necessary by the treating provider.

Print Name: _____ Relationship To Child _____

Signature: _____ Date: _____