Sedona Dental Group

Consent to Treatment of Minors

Patient Name:__________________________ Date of Birth:__________

Many times parents/guardians find themselves unable to accompany their children to dental appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

PERMISSION TO TREAT (Please Print Clearly)
I, ______________________________, give permission to Sedona Dental Group and staff to perform all dental treatment on my child________________________ including, but not limited to fluoride treatments, diagnostic radiographs, examination, composite fillings, sealants and extractions. If additional treatment is needed, Sedona Dental Group has my permission to perform that treatment regardless of my presence in the office. In the event of an emergency, Sedona Dental Group and staff have my permission to take any and all necessary steps to ensure the safety and well-being of my child. I understand and agree to Sedona Dental Group's Treatment of Minor Consent Form and its terms.
Name of Parent/Legal Guardian (please print):___________________________
Signature of Parent/Legal Guardian:__________________________________
Relationship to Patient:____________________