DENTAL TREATMENT OF A MINOR
(ages 0-18)
CONSENT FORM

DATE:_____

CHILDS NAME:_____**DATE OF BIRTH**_____

Your child is in need of some basic dental care. This form explains the care that is needed and requests your permission to provide that care:

Routine exam and cleaning

X-rays

Sealants Fluoride

#:_____ **Initial:**_____

Dental Fillings:

#:_____ **Initial:**_____

Stainless Steel Crowns

#:_____ **Initial:**_____

Nerve or Pulp Treatment

#:_____ **Initial:**_____

Extraction or Removal of the Tooth

#:_____ **Initial:**_____

I give my consent for the treatment of the above checked services

_____ _____

Parent or Guardian Signature

Date

Printed Name

Relationship