Hamilton
Pediatric Dentistry P.C.

Consent for treatment Form

Child's Full Name_____ DOB _____

I am the parent or legal guardian of the patient and there are no court orders now in effect that prevent me from signing this consent. I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. I authorize Dr. Hamilton and her staff to perform any necessary dental treatment for my child including but not limited to comprehensive exam, cleaning, x-rays, fluoride treatment, administration of local anesthetic, use of nitrous oxide, fillings, crowns, nerve treatment, and extractions whether or not I am present at the time treatment is rendered.

For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs and patient information.

I understand that it is my responsibility to inform Hamilton Pediatric Dentistry of any changes in my child's medical status.

_____ _____

Signature of Parent/Guardian Date

Authorization for Non Parent to Bring Child to Appointment

I authorize _____ (Name & relationship of person accompanying child) to accompany my child, _____ to his/her dental appointment. I agree to the following treatment to be performed in my absence:

Any necessary dental treatment for my child including but not limited to comprehensive exam, cleaning, x-rays, fluoride treatment, administration of local anesthetic, use of nitrous oxide, fillings, crowns, nerve treatment, and extractions.

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment. Phone Number: _____

If treatment recommendations change during treatment and I am not able to be reached, I authorize the person accompanying my child to make an informed decision and authorize Dr. Hamilton to perform the treatment.

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____ ***This authorization is good for one year from date.***