DENTISTRY FOR CHILDREN

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I as parent of (_____) (_____) give
First and last name of patient — Patient's date of birth

permission for, (_____) to accompany and give full consent to
First and last name of person bringing child to appointment

Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff for the following dental procedures: examination, cleaning, fluoride application, required x-rays for proper diagnosis, necessary for treatment, conscious sedation, and nitrous oxide.

I consent and authorize Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their staff to discuss personal medical/dental history about my child with the above authorized adult.

I request and authorize Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff to examine, clean, apply fluoride and provide my child with comprehensive dental treatment include but not limited to: silver/white fillings, crowns, extractions, impressions, space maintainers, pediatric bridge, sealants, conscious sedation, and nitrous oxide. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Tarver, Dr. Scheps, Dr. Depew, and Dr. Luce to diagnose and/or treat my child's dental condition.

I understand that dental treatment may change. I authorize the above adult to consent to any treatment changes considered necessary by the dentists.

All of my questions have been answered to my complete satisfaction and I give full permission to Dr. Tarver, Dr. Scheps, Dr. Depew, Dr. Luce and their office staff to treat my child. I understand that I will be responsible for any charges incurred on my child for dental treatment.

_____ _____
Print name of Parent or Legal Guardian — Relationship to Child

_____ _____
Signature — Today's Date

Please provide our office with a phone number in case we need to contact you on the day of your child's dental appointment.

_____ _____
Phone number you can be reached on day of appointment — Date of Appointment