

## Consent for Treatment

Consent for treatment for \_\_\_\_\_  
(child's name)

I request and authorize Dr. Kyle Pedersen, assisted by dental auxiliaries of his choice, to examine, clean, apply fluoride, and provide treatment for my child's teeth. I further request and authorize the taking of any *necessary* dental x-rays needed to diagnose and/or treat my child's dental condition. In addition, photographs may be taken of my child and their teeth for diagnostic and educational purposes. I acknowledge that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Furthermore, Dr. Pedersen will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and variable voice tone.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date