Consent for Treatment

Consent for treatment for_______________________________________

(Child's name)

I request and authorize Dr. Lisa Hanson, Dr. Maureen Sevandal, and Dr. Jason Holt to examine, 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, we 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