DRS. KEARNS, ASHBY, RAJCHEL & ASSOCIATES

DENTISTRY FOR INFANTS, CHILDREN & TEENS

DWIGHT J. ASHBY D.D.S. **NANCY L. RAJCHEL, D.D.S.** **JEFFREY D. KEARNS, D.D.S.**

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DENTAL TREATMENT CONSENT FORM

Patient(s) Name(s): _____

I, (being the parent or guardian of the above minor patient) do hereby authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Kearns, Ashby or Rajchel may deem necessary during treatment.

I understand that Dr. Kearns, Ashby or Rajchel and other authorized personnel as he/she may designate to treat the above named patient will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Kearns, Ashby or Rajchel. **All treatment and procedures will be discussed with you before the appointment. This authorization is valid until revoked by me in writing.**

I agree to be responsible for full payment of all charges for dental services performed on the above-named patient.

Date: _____

_____
Signature of Parent/Guardian/Self if over 18

_____
Relationship

_____
Witness