

KEARNS & ASHBY, D.D.S., P.C.

CHILDREN'S AND ADOLESCENT'S DENTISTRY

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DENTAL TREATMENT CONSENT FORM

Patient Name:

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, Rajchel or Kearns may deem necessary during treatment.

I understand that Dr. Kearns, Ashby, Rajchel or Kearns 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, Rajchel or Kearns. 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

Relationship

Witness