



Consent For Dental Treatment

I request and authorize Dr. Michele Horton and/or Dr. Ellena Vranas, assisted by dental auxiliaries of her 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 identification purposes. I acknowledge that there have been no changes in my child's medical history since his/her last dental visit and I understand it is my responsibility to inform this office of any changes in my child's medical history. ie; allergies, medications, recent surgery.

I hereby authorize the doctor and her dental auxiliaries to perform the necessary treatment to restore my child's teeth to a healthy state. I authorize the doctor to use restorative dental materials that have been approved by the ADA and chosen by the doctor to achieve the desired optimal results.

I authorize this office to release all information necessary to secure the payment of benefits. I understand that as a Parent or Guardian I am financially responsible for all charges whether or not paid by insurance.

I understand that my child will undergo dental treatment, and I feel I understand sufficiently and am willing to proceed with treatment. All my questions were answered satisfactorily.

Parent's or Legal Guardian's Signature Date

Doctor's Signature Date

Witness Signature Date