AestheticDentistry
OF STUART

PATIENT NAME _____ DATE OF BIRTH _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Aesthetic Dentistry of Stuart. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (composite fillings or crowns), periodontal (gum) treatments and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

Signature _____ **Date** _____

FOR PARENTS OR LEGAL GUARDIANS

This section needs to be completed for children under the age of 18 by a parent or legal guardian only.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

If child is over 14, please check one:

- ☐ Since my child is over the age of 14, I also give permission for him/her to present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.
- ☐ Although my child is over 14, I wish to be present for all treatments performed.

Signature _____ **Relationship** _____ **Date** _____

This consent shall be considered in effect until rescinded or revoked.

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