

Advanced Dental & Denture

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CONSENT FORM TREATMENT FOR MINOR CHILD

I am the (parent or guardian) of _____ (name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of 1st Impressions Dental & Denture's dentist. This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate and materials for such treatment.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Parent Signature _____

Date _____

Witness _____

Date _____