1st Impressions Dental and Denture
9835 16th Ave SW, Suite 101, Seattle, WA 98106
Phone: (206) 763-8883 | Fax (206) 786-8887

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 o local anesthetic, reasonable restraint as needed, and use of appropriate and materials for such treatment.

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

Parent Signature_____ Date_____

Witness_____ Date_____