

# Parental/Legal Guardian Consent for Dental Treatment

I give permission to Bowser Dentistry to treat my child. I give my authorization for all dental treatment that may be required in my absence for the child named below. I agree to pay for all of the services provided to my child.

This authorization shall be effective until: \_\_\_\_\_

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to \_\_\_\_\_ prior to this date.

I hereby give Bowser Dentistry consent to treat \_\_\_\_\_ for a checkup appointment (exam, cleaning, x-rays, fluoride).

Signature of parent or guardian: \_\_\_\_\_

I hereby give Bowser Dentistry consent to treat \_\_\_\_\_ for sealants (protective coatings on permanent or primary teeth).

Signature of parent or guardian: \_\_\_\_\_

I hereby give Bowser Dentistry consent to treat \_\_\_\_\_ for a cavity requiring a filling (local anesthesia and composite restorations).

Signature of parent or guardian: \_\_\_\_\_

If there has been any change to your child's medical history, including allergies, medications, and surgeries, please write them down in the space below.

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