Hamilton Pediatric Dentistry, PC
3299 Clear Vista Ct.
Suite B
Grand Rapids, MI 49525
Phone:

Consent for treatment Form

Child's Full Name_____

I am the parent or legal guardian of the patient and there are no court orders now in effect that prevent me from signing this consent. I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. I authorize Dr. Hamilton and her staff to perform any necessary dental treatment for my child including but not limited to comprehensive exam, cleaning, x-rays, fluoride treatment, administration of local anesthetic, use of nitrous oxide, fillings, crowns, nerve treatment, or extractions whether or not I am present at the time treatment is rendered.

For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs and patient information.

I understand that it is my responsibility to inform Hamilton Pediatric Dentistry of any changes in my child's medical status.

_____ _____

Signature of Parent/Guardian Date