Permission to Treat Minor Patient

Child's Name: _____ Child's Date of Birth: _____

Please perform the following procedures/treatments on my child (please check all that apply):

☐ Examination ☐ Cleaning

☐ Fluoride Treatment ☐ Radiographs (X-rays)

☐ Restorative procedures

- ☐ All procedures listed on previously signed treatment plan
- ☐ Only the following restorative procedures: _____
- ☐ Local Anesthetic (Novacaine)

☐ Nitrous Oxide (laughing gas)

Are there any changes to your child's medical history? **YES** **NO**

If yes, please give a brief synopsis of the changes: _____

_____

Please list any medications your child is currently taking: _____

_____

Please list any allergies your child has: _____

_____

Please provide phone number at which you can be reached at while your child is at their appointment: _____

I give the doctors and staff at North Branch Dental permission to treat my child. I understand what services will be rendered to my child in my absence and have had all questions regarding those services answered to my satisfaction.

Signature: _____ Print Name: _____

Date: _____