

PEDIATRIC DENTISTRY OF NEWNAN

Dr. Kim J. Mathews

Consent for Dental Treatment

I am the parent, guardian or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Kim J. Mathews and her staff to perform any necessary dental services including but not limited to comprehensive examinations cleanings, x-rays and photographs as necessary for diagnostic purposes, any necessary treatment, and the administration of anesthetics that are deemed advisable by Dr. Mathews, even in the event that I am not present when treatment is rendered. I understand that dental treatment for children includes efforts to guide behavior by helping them understand the treatment in terms appropriate for their age. Dr Mathews will provide an environment that will help children learn to cooperate during treatment including explanations, demonstrations of procedures and instruments, praise and using positive enforcement. I will be responsible for any charges incurred for my child during dental treatment.

Parent/Legal Guardian Name (printed)

Parent/Legal Guardian (Signature)

Date

Relationship to Patient

Permission Form

I, _____, give permission to the following parties listed below:
(Parent/Guardian)

Relationship to Patient: _____
(Guardian Name)

Relationship to Patient: _____
(Guardian Name)

the ability to authorize dental treatment and/or change existing dental treatment for:

(Patient Name)

This waiver allows the parties noted above to sign consent for treatment, decide for or against any treatment changes, and to be the responsible party if there should be an emergency. All necessary information regarding the patients visit will be given to the party noted above. If you, the parent/guardian, would like to speak with Dr. Kim Mathews or a staff member concerning treatment, it will be your responsibility to call 770-251-5777. If there is a copay or patient portion due on the day of treatment, it is the parent/guardians responsibility to call in advance of the patient's appointment time to pay over the phone with a credit/debit card. No billing statements will be sent home for the amounts that are due day of service.

Parent/Guardian Signature

Date

(Over)