CARLISLE DENTAL STUDIO P.C. - Consent for Treatment of a Minor

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, our office staff will be delighted to help you.

1. I hereby authorize and direct Doctors, and the staff of Carlisle Dental Studio P.C. to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental assistants, dental hygienists) other than the dentist.

3. I authorize the use of accepted behavior management techniques and understand that the doctors are not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.

4. I have answered all the questions about my or my dependent’s medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should receive oral medications and/or anti-anxiety agents. I will not hold Doctors Golalic or any of their staff responsible for any errors or omissions I may have made. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

5. I authorize other individuals with whom I have placed the care of my child, such as other family members, caregivers, to sign consent for dental treatment for my child should they bring my child to any future appointments.

6. I authorize Carlisle Dental Studio P.C.to forward a review of findings and/or any other dental information to the referring doctor or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read & understand this consent & the meaning of its contents. I further understand that this consent shall remain in effect until terminated by me.

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Patient’s Name Date

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Parent or Guardian Relationship to patient