Pediatric Dentistry of Garden City/Syosset

General Consent

I hereby give my consent to the Doctors and Staff to treat my child which may include the following dental procedures:

complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), study models, photographs, and other diagnostic aids deemed necessary to make a thorough diagnosis of my child's dental needs.

I authorize the office to provide any information to other Doctors (Physicians, Dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about the proposed treatment. I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of my child/the patient.

Parents/Guardians: for future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information:

Name of authorized person(s) to accompany my child for future treatment visits:

1. _____ **Relationship to Child** _____
2. _____ **Relationship to Child** _____
3. _____ **Relationship to Child** _____
4. _____ **Relationship to Child** _____

Parent/Guardian Signature _____ **Date** _____