Tot2Teen DENTAL

"Your Child's Care is Our Focus!"

Patient's Name: _____

Consent for Dental Treatment

I, the undersigned, consent to dental treatment on _____ as presented on the treatment plan dated _____ (DD/MM/YY). Dr Anita Gartner and staff have fully informed me of the anticipated nature, risks, benefits and possible outcomes of the proposed treatment. I was also informed of the details of any alternative treatment, including no treatment. I agree to accept the treatment as recommended by Dr Gartner.

I understand that individual reactions to treatment cannot be predicted, and I agree to report any unanticipated reactions that occur during or following any treatment as soon as possible. I acknowledge that no guarantees or assurance have been given by anyone as to the results that may be obtained.

I was informed that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions. I agree to report any change in my child's health as soon as possible.

I have discussed all of the above with Dr. Gartner and her staff and all my questions have been answered. I am aware that I am ultimately responsible for any fees associated with the recommended treatment. I have been informed that payment is expected once treatment has been rendered. In the case of a general anesthetic appointment, a payment towards the treatment must be received 2 weeks in advance of the appointment.

I have read and understand this authorization and give my consent to as above.

_____ _____

Signature of Patient/Parent/Legal Guardian | Relationship to Patient

_____ _____

Print Name | Date (DD/MM/YY)

_____ _____

Signature of Dentist | Date (DD/MM/YY)

_____ _____

Signature of Witness | Date (DD/MM/YY)

Dr. Anita B Gartner Inc. *Certified Specialist in Pediatric Dentistry*

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