CONSENT TO TREATMENT

PATIENT'S NAME: _____ DATE: _____

I hereby authorize Dr. Bryant and/or the associates with The Kid's Dentist to perform upon my child, the above named patient the following initial procedure(s):

_____Exam & X-rays_____

_____

Dr. Bryant & Associates have fully explained to me the purpose of the procedures(s) and has also informed me of expected benefits, and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I acknowledge that no guarantee or assurances have been made to me concerning the results intended from the procedure(s)

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

I hereby consent to the proposed dental treatment.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

DENTIST CERTIFICATION:

I hereby certify that I have explained the nature, purpose, benefits, risks of, alternatives (including no treatment and attendant risks), to the proposed procedure(s). I have offered answers to any questions and have answered all such questions. I believe that the patient/parent/guardian fully understand what I have explained and answered.

Dentist Signature: _____

Print Name: _____ Date: _____