

Consent for Treatment

I, being the (choose one mother, father, guardian) of _____ hereby give my consent
(name of child)
to Dr. Bonamer to perform such treatments, services, medications, anesthesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease.

1. If any conditions are discovered in the course of treatment which, in the opinion of the doctor authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures.
2. I will be informed of the proposed procedures and/or treatment. The alternatives to, the risk of, and the possibilities of complications from the proposed procedure and/or treatment-including those related to anesthesia will be explained to me in sufficient detail to permit me to make a reasonable decision in granting this consent.
3. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

I certify that I have read and fully understand the above Consent, that all of my questions were answered to my satisfaction and the explanation described above were made to me to my satisfaction.

Signature Consenting Party

Date

Signature of DDS Obtaining Consent

Date

If consenting party is not available to sign the above consent, note:

Means of Oral Consent

Date

Witness

Time



a lifetime of beautiful smiles

Therese M Bonamer

Board Certified Pediatric Dentistry

DDS, Inc.