Exam Consent

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I understand that by signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

X-Rays & Examination
I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Medical Photography Consent
I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Dental Cleaning and Fluoride Treatment
I authorize The Doctor and/or her staff members to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps prevents cavities.

Drugs and Medication
I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.

Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards	**__ I consent** **__ I do not consent**
I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog; Facebook and Yelp	**__ I consent** **__ I do not consent**

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors, health practitioners and as required by law.

Parent's Name and Relationship to Child: **Date:** __________

No need to print. This form can be electronically signed at the office if you prefer to save paper. Please e-mail or fax the form to our office in advance of your appointment.

Parent's Signature: ______________________