Patient’s Name: Birthdate:

I give consent for myself/mychild to receive dental treatment deemed necessary by the providers at the Open Door Medical Centers. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), flüoride treatments, sealants, restorations (amalgam orcomposite fillings and crowns), periodontal (gum) treatments, endodontic (rootcanal) treatments, extractions, and theuse of local anesthetics. I understand that the use of local anesthetic scarries a small risk for swelling, bruising, allergicreaction, changes in pain perception, orprolonged anesthesia. This consentshall be considered in effect until rescinded or revoked.

(print your name) (relationship) (date)

(your signature) (witness) (date)

This section needs to be completed for children undertheage of 18 by a parentor legal guardian ONLY.

I affirm that I am the parentor legal guardian for the above named minör child. If I am unable to Accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: Relationship: Name: Relationship: Name: Relationship: Name: Relationship:

If child is over 13, please checkone:

\_ Since my child is overtheage of 13, I also give permission for him/her top resent for treatment accompanied by an adult. I understand that no invasive treatment, such as extractionsor the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I can not be reached, I give permission to perform what ever therapies are deemed necessary by the treating provider.

Although my child is over 13, I wish to be present for all treatments performed.

(signature of parentor legal guardian)

***This consentsh all be considered in effect until rescinded or revoked.***