

**Direct Dental Care-Consent Form for Minors**

I hereby authorize and direct the dentists at this practice and/or dental auxiliaries to perform upon my child (or legal ward) the following dental treatment procedures, including the use of **any necessary or advisable local anesthesia, radiographs ( X-rays) or diagnostic aids** when indicated.

1. Cleaning of teeth and the application of topical fluoride.
2. Application of sealants to the grooves of the teeth
3. Treatment of diseased or injured teeth with dental restorations (fillings).
4. Replacement of missing teeth with dental prosthesis
5. Extraction (removal) of one or more teeth.
6. Treatment of diseased or injured oral tissue (hard/soft)
7. Postponing or delaying treatment at this time.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable to the child's oral health and well being in the professional judgment of the dentists at this practice.

By signing this form I authorize the dentist/dental auxiliaries to perform the necessary indicated procedures on my child (legal ward) in situations I am unable to accompany them.

I also authorize the dentist/ dental auxiliaries to perform the necessary indicated dental procedures on my child (legal ward) if he/she is accompanied by their guardian, whose details are furnished below.

I have given them the rights to take informed decisions for my child.

**Patient's Name** \_\_\_\_\_

**Parents Name** \_\_\_\_\_

**Legal Guardian's Name** \_\_\_\_\_

**Relation to the Child & Parent** \_\_\_\_\_

**Signature of the Parent/Legal Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_ **Witness** \_\_\_\_\_ **(Staff)**