THE BRUSH STOP
Pediatric Dentistry & Orthodontics

CONSENT FOR INITIAL VISIT

As the legal guardian, authorization is hereby granted to do an examination, take X-rays deemed necessary by Dr. Khoury, clean teeth, give fluoride treatment, and or alternatives, and provide oral hygiene instructions if deemed necessary. I also give permission to provide my child with emergency care if needed. I authorize my pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child. I further understand that this consent will remain in effect until such time that I choose to terminate it. I understand that I accept responsibility for payment of services rendered. I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references. I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.

I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Khoury and the staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using a variable voice tone.

Signature:_____ Date:_____

Relationship to Patient:_____