COASTAL MAINE
Pediatric Dentistry

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Consent for Dental Treatment

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Scholl 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 tone of voice.

I request and authorize Dr. Scholl and her staff to examine, photograph, clean, and provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide/oral sedation if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Scholl to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes.

I agree I or my representative will remain on site during this child's dental appointment. I understand that the parent or guardian who brings the child for his/her visit is responsible for payment. Our office will not intervene with divorce decrees or individual arrangements and any reimbursement of payment for services must be made between divorced or separated parents as necessary.

By accompanying **(Child's Name)**_____ for treatment and signing below, I represent that I have the right to direct their care or have obtained the consent of any person/entity required to authorize treatment.

Completed by (print): _____ Relationship to patient: _____

Signature _____ **Date** _____/_____/_____