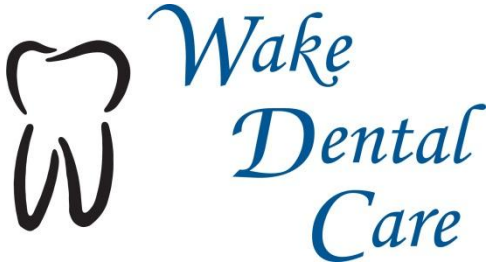

TREATING MINOR IN ABSENCE OF PARENT

I have been informed that the following procedures are necessary for my child:

- ☐ Prophy (Cleaning)
- ☐ Bitewing X-Rays (Show decay between teeth)
- ☐ Panoramic X-ray (shows entire mouth including adult teeth yet to erupt)
- ☐ Fluoride (foam trays or varnish) YES _____ NO _____
- ☐ Sealants
- ☐ Other_____

Although every effort will be made to adhere to the proposed treatment plan, unforeseen circumstances or conditions may require a departure from the plan.

After restorative treatment, your child may experience pain and swelling. Due to local anesthetic during treatment, there is a possibility that the child may bite the inside of the mouth or tongue before the anesthesia wears off, and that the child must be instructed not to do so.

Consent

If I do not remain in the dental office while my child is receiving dental treatment, I am leaving the treatment up to the doctor's judgment and experience and understand that other treatment may have to be rendered, if necessary, to obtain optimal dental health of the tooth/teeth being treated.

My child has the following health history changes since his/her last visit:

_____

In case it is necessary to contact me during my child's dental visit, my cell phone number is:

_____

Child's Name:_____

Parent or Guardian's Name:_____

Signature:_____ Date: _____

THIS COMPLETED FORM MAY BE FAXED TO 919-363-3134