OPEN DOOR
FAMILY MEDICAL CENTERS

Patient's Name: _____ **Birthdate:** _____ **Chart #**_____

☐ I give consent for myself/my child to receive **dental** treatment deemed necessary by the providers at the Open Door Family Medical Centers. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.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 under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for treatments:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

If child is over 13, please check one:

❑ Since my child is over the age of 13, I also give permission for him/her to present for treatment *unaccompanied* by an adult.

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

_____

(Signature of parent or legal guardian)

This consent shall be considered in effect until rescinded or revoked.

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