Denmark Family Dentistry

Parental Consent Form for Dental Treatment

Child's Name: _____ Date: _____

I give permission to Denmark Family Dentistry to provide care to my child. **I understand that by signing below I authorize the following procedures to be performed as deemed necessary by Denmark Family Dentistry. Please initial all that you consent to:**

_____ **Exam and Dental Cleaning**

_____ **Necessary X-Rays**

_____ **Fluoride Treatment**

I understand as the parent/guardian of the child that I am financially responsible for all payments for treatment rendered for the child. If your family has dental insurance, please have your child present the most recent copy of your insurance card if you would like us to submit your claim for you.

Parent/Guardian Print: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Updated: 03/10/2022