



HARBOR kids' TEETH
BOARD CERTIFIED PEDIATRIC DENTIST
LISA A. BLOCK, DMD, MS

CONSENT FOR TREATMENT REGARDING: _____ (name of patient)

1. The undersigned hereby authorizes the doctors to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. In addition, I understand that using anesthetic/sedation agents embodies a certain risk.
3. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment. If any treatment should vary from that being contemplated, and if there is no reasonable opportunity for additional explanation and authorization, the parent or guardian further authorizes Dr. Block and associates to proceed with such treatment they consider advisable based on their opinion and judgment.
4. In Pediatric Dentistry as in all other health care treatment, there can be no guarantees of particular outcomes. The anticipated benefits are based on results from treating similar conditions and may vary depending on patient cooperation, individual physical and psychological differences, and a number of other factors.

Signature of Parent or Guardian

Date

Witness