LANSDOWNE
DENTISTRY
BY DESIGN

CONSENT FOR TREATMENT TO A MINOR CHILD

Date:_____

My child, _____, age_____ has permission to have necessary dental treatment performed. This treatment may include, but is not exclusive of:

- Dental radiographs
- Fluoride treatment
- Panoramic – full mouth set of x-rays

Health History changes are _____

Date of Last Physical: _____

Weight: _____lbs.

Health conditions (surgery, illnesses, or injuries since last dental visit):

_____

_____

Medications:

(Include over the counter medications and herbal remedies.)

NAME	DOSAGE	HOW OFTEN	TIME OF DAY TAKEN

Name of Physician(s): _____

Phone(s) #: _____

I do ❑ or do not ❑ have any dental concerns. If you do have concerns, please describe them below:

_____

_____

Parent/Guardian Signature _____