Consent for Treatment

I am the parent or guardian of_____,who is a minor , and I authorize examination and treatment as necessary by or under the supervision of Dr. Tracy Kim. This includes radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and materials for such treatment. I understand that the treatment plan to be presented, along with the fees outlined are subject to change depending on the time lapsed since the examination and the extent of the dental pathology. I understand that no treatment results can be guaranteed.

Furthermore, by signing this, I agree to be responsible for the full payment of all charges on the day of service for all dental treatment performed on the above named patient. I give permission for my insurance company to pay benefits directly to Pediatric Dentistry of Oldham County.

I have read and understand the above information and the information given to me verbally.

Parent signature _____

Patient Name _____

Date _____

Witness _____ Date _____