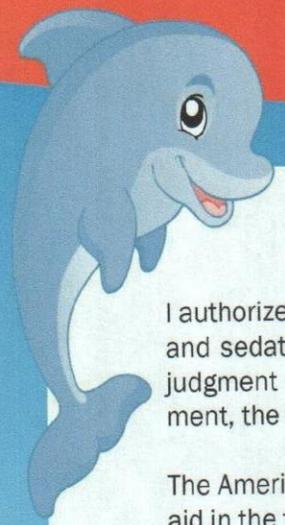


**1367-B EAST GARRISON BOULEVARD
GASTONIA, NC 28054-5144
980.320.8479
WWW.GASTONIAPEDIATRICDENTISTRY.COM**



Consent to Treat

I authorize the rendering of diagnostic and treatment procedures, including fluoride, local anesthesia and sedation, by the doctors and dental staff of Gastonia Pediatric Dentistry, in their professional judgment may be deemed necessary or beneficial. However, before rendering any definitive treatment, the proposed treatment plan will be presented and discussed with the parent or guardian.

The American Academy of Pediatric Dentistry recommends fluoride be applied twice per year to help aid in the formation of tooth enamel, to repair early stages of tooth decay and to help prevent decalcification. For these reasons, please be aware that this will be applied at each cleaning unless otherwise notified.

I further understand that this consent will remain in effect until that I choose to terminate it.

Patient's Name: _____ Date: _____

Signature of Parent/Guardian: _____

Witness: _____

Consent for the use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.

I further understand that this consent will remain in effect until I choose to terminate it.

Patient's Name: _____ Date: _____

Signature of Parent/Guardian: _____

Witness: _____

