



Dentistry for Kids

Amy Waxman, DMD & Lisa Honig, DDS
Pediatric Dentistry & Orthodontics for Infants, Children, & Teenagers

Consent for Treatment

I, being the parent or guardian of _____, do hereby request and authorize the dental staff and Doctors to perform necessary dental services for my child, including x-rays (if indicated), local anesthetic agents, and any other services deemed advisable and necessary by the doctor.

I understand that I will have all treatment options explained to me by Dr. Waxman, Dr. Honig, and their staff, and will have sufficient opportunity to discuss my child's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from the treatment plan, compared with alternative approaches and/or no treatment.

I understand that during the course of the patient's treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed.

In the event of an unforeseen emergency, Dr. Waxman, Dr. Honig and their staff have my permission to take any and all necessary steps to ensure the safety and well being of my child.

I authorize my Pediatrician or other Physician/Medical Facility to release any and all pertinent medical information regarding my child.

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

Signature of Parent or Legal Guardian: _____

Date: _____