BRUSH
Pediatric Dentistry®

Parental Consent for Dental Treatment

I, _____ understand that by signing this document I give
(Parent/ Guardian Name)
Consent for _____ who is accompanying my child/children
(Accompanying Adult Name)
_____to their dental appointment for treatment at
(Child/ Children Name(s))
Brush Pediatric Dentistry. I understand that if changes in treatment occur, indicated by the treating doctor a team member will attempt to contact me regarding said change. I am aware that if I am not reachable at the time of the phone call, the person accompanying my child will be informed and will be asked for permission to proceed. Lastly, by consenting to this document, I understand that I am the responsible party for any payment that is due for this appointment.

Please select one:

☐ I will call Brush Pediatric Dentistry at (630)504-2223 to provide payment in advance of the appointment.

☐ The adult accompanying my child will provide payment at the time of service

Please provide a phone number that you will be reachable during the appointment time for your child/children _____
(Phone Number)

Please leave any questions or concerns that you might have for this appointment:

_____

_____

_____

_____

_____

_____

_____

_____

Parent/ Legal Guardian Signature: Date:

_____ _____