Springbank
DENTAL CENTRE

Parental Consent

Patient's Name: _____ **Date:** _____

I _____ give consent for my child to have the following procedures completed during their routine examination at Springbank Dental Centre.

_____ Recall Exam

_____ Fluoride Treatment

_____ Radiographs (X-Rays), as recommended by the dentist (Bitewings once per year, Panoramic every 5 years)

_____Intra-oral Photographs (no-charge)

I understand that refusal of any of the above procedures could result in an incomplete diagnosis or treatment of my child.

_____ _____

Parent / Legal Guardian Signature **Date**

****** This form is valid until age of consent or until revocation ******