Allouez Family Dental Center

Parental Consent Form for Dental Treatment

Child's Name: ____________________________________ Date: _____________________________

Date of Birth: ______________________

1. Any changes in your child's health since their last visit? ________________________________

   ____

2. Please list any current medication(s): ____

   ____

3. Any known allergies: ____

Please check the following treatment that you give consent to:

Dental prophylaxis (cleaning)
Exam
X-rays as needed
Fluoride
Sealants
Restorative procedure deemed necessary that have been previouly discussed

Phone number of parent/guardian ____________________________________

If you have any questions/concerns, please feel free to call our office at (920) 339-8980.

Signature: ______________________________________ Date __________________________________

Print name: ____