



**Atlantic Dental Group**

General Dentistry

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**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_

Name of minor/child

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured Parent/Guardian