Robert Anderson D.D.S
3775 Stockton Hill Rd Ste.C
Kingman, AZ 86409

Patients Name: _____Birthdate:_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at **HIGH DESERT DENTAL.** These procedures include, but are not limited to; examinations, oral prophylaxes(cleanings),fluoride treatments, sealants, restorations(amalgam or composite fillings and crowns),periodontal (gum) treatments, endodontic(root canal) treatments, extractions and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____

(Signature) (Date)

I affirm that the persons listed below are allowed access to my account and/or treatment plans.

Name: _____Relationship:_____

Name: _____Relationship:_____

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals below to accompany my child for dental work.

Name: _____ Relationship_____

If child is over 13, please check one:

_____ Since my child is over the age of 13, I give my permission for him/her to present for treatment UNACCOMPANIED by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are necessary by the treating provider.

_____Although my child is over 13, I wish to be present for all treatments performed.

(Signature of Parent or Legal Guardian)_____Date_____