Metropolitan
Pediatric Dental
Associates

Parent/Guardian Consent for
Preventive Dental Care (Dental Check-Ups)

Child's Name_____ DOB_____

Parent/Guardian's Name_____

Caregiver's Name_____ Relationship to Patient_____

If dental procedures are diagnosed at regular check-ups or if emergency treatment is needed, an additional consent to treatment must be signed or agreed to by legal guardian with Metropolitan Pediatric Dental staff before any treatment is rendered.

Parent/Guardian Signature_____ Date_____