CHILDREN'S DENTAL CENTER OF CENTRAL IOWA, PLC

GENERAL CONSENT FORM FOR DENTAL TREATMENT

The procedure or treatment my child will have is DENTAL REHABILITATION in the office setting.

I have been given a proposed treatment plan for my child and it has been explained to my satisfaction. I understand, however, that treatment could change, and I give permission for Dr. Wade/Dr. Bremen, to use their professional judgment to determine the appropriate/best treatment for my child.

I understand that any fees quoted to me are estimated only and that the actual amount that I owe Dr. Wade/Dr. Bremen, may be different than the estimate if treatment changes.

Taking this information into consideration, I agree to allow Dr. Wade/Dr. Bremen, and other necessary staff to perform procedures or treatments as are found necessary in the judgment of Dr. Wade/Dr. Bremen.

I_____ _____
(parent/guardian – please print) (signature)

Relationship_____ _____
(mother, father etc) Child's name

Witness_____ Date_____