Joel B. Peterson, D.D.S.
3466 Holiday Court
Bettendorf, Iowa 52722

Practice Limited to
Pediatric Dentistry

(563) 332-1321
Fax (563) 332-3905

CONSENT TO TREATMENT

Patient Name: _____

I (being the parent or guardian of the above minor patient) do hereby authorize and request the performance of dental services for the above minor patient and the use of whatever procedures Dr. Joel Peterson may deem necessary during treatment.

I understand that Dr. Joel Peterson and such assistants as he may designate to treat the above mentioned minor patient will use restorative, oral surgery, endodontic, orthodontic and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics (ex. xylocaine, lidocaine) or analgesia (nitrous oxide) which may be deemed advisable by Dr. Joel Peterson.

I understand that an exam may consist of a thorough examination, prophylaxis, fluoride treatment (appropriate for age), and appropriate radiographs for diagnosis.

I understand that the treatment plan presented along with the fees could change depending upon the time elapsed since clinical examination, radiographic exam, caries excavation and/or extent of dental pathology. I acknowledge that I have read the above mentioned information and have had the opportunity to ask and have any questions answered to my satisfaction prior to signing.

Date: _____

_____
Signed

_____
Relationship

_____
Witness