FISHER & ZITTERICH
FAMILY | COSMETIC | IMPLANT
DENTISTRY

General Consent Form

Patient's Name: _____ Birthdate: _____ Date: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Fisher and Zitterich Dentistry, PLLC. These procedures include, but are not limited to; examinations, radiographs (including CBCT), oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, implants, oral surgery 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 This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

(Print your name) (Relationship) (Date)

_____ _____ _____

(Your signature) (Witness) (Date)

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

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 named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If child is over 13, please check one: ☐ Since my child is over the age of 13, I also give 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 deemed 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)

This consent shall be considered in effect until rescinded or revoked.