Angel Dentistry
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Phoenix, AZ 85024
(602)788-2008

DENTAL CONSENT FORM

As health professionals, it is necessary that we obtain your consent for dental/oral treatment of yourself or child. Please read this form carefully and ask any questions that might not be clear or you may not understand.

I, _____authorize Dr. Amber Angel and her assistants to treat myself or child_____.

Numbers 1 – 8 MUST BE INITIALED

In general terms those procedures might include but are not limited to:

_____1. Dental cleaning, fluoride application and radiographs as necessary.

_____2. Application of sealant to dental fissures.

_____3. Restoration of broken teeth or fillings.

_____4. Treatment of infected teeth or gums.

_____5. Extractions of one or more teeth.

_____6. Use of Analgesia – Nitrous oxide that will help relax the patient during treatment.

_____7. Use of sedative drugs for the control of nervousness or negative behavior.

_____8. Complete Exam and x-rays.

_____ _____ _____
Patient/Parent/Legal Guardian Signature Date Witness

Associates Name:_____ Associates Signature:_____