SAMUELS DENTAL ARTS P.C.

Consent for Treatment of a Minor

I am the parent or guardian/representative of _____, who is a minor child and I authorize examination and treatment, as necessary, by or under the supervision of Dr. Peter J. Samuels and/or Dr. Julie C. Berger. This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and materials for such treatment.

I have read and understand the above information and the information given to me verbally. By my signature below, I consent to the treatment described in this form.

Indicate your relationship to the patient: Patient _____ Guardian/Representative _____

Print Name: _____

Signature: _____ Date: _____

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