# CONSENT FOR DENTAL TREATMENT

I, _____, the parent/guardian of _____,

Do hereby authorize Dr. Tina Nguyen and licensed staff to the following dental procedures: Complete diagnosis and evaluation, x-rays, study models, photographs or any other diagnostic aids deemed necessary by Dr. Nguyen to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Nguyen to perform any and all forms of treatment, medication and therapy that may be indicated including the administration of local anesthesia and/or nitrous oxide.

_____ _____

Signature of Parent/Guardian Date

_____

Relationship to Patient