

RELEASE FOR TREATMENT

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or legal guardian before Dr. Jennifer Adam can perform any necessary dental services.

I _____ being the parent or legal guardian of the above minor do authorize and request the performance of dental service for this patient. I also authorize Dr. Jennifer to perform any additional dental services that may be deemed necessary during treatment for the above patient. (Example: having to do a nerve treatment and a crown on a tooth that was treatment planned for a crown today). Please note: we will make every effort to inform you of additional treatment if needed.

Occasionally, (for about 1% of our patients) it becomes necessary to control excessive head, arm, and leg movement in order to provide safe, comfortable, and quality dental treatment. The most compassionate technique we have found for immobilizing these special patients involves the use of the Papoose Board(“sleeping bag”/”Protective blanket”) and one or more seat/safety belts. We believe that this approach is much less traumatic than restraining your child using several adults.

Dr. Jennifer will assume, unless you tell her otherwise, that your permission to use any information (ex: photos, charting, video, etc.) of your child to educate other parents, residents, medical personnel, etc. on matters pertaining to pediatric dentistry.

At Children’s Dentistry we will make every effort to arrange for you to pay for dental services provided. You, the parent or guardian, must be financially responsible for any bill incurred for the dental services provided.

Date: _____

Signed: _____

Relationship: _____



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