

Raenie Roberts, DDS, MS
Board Certified Orthodontist

John Roberts, DDS, MS
Board Candidate Pediatric Dentist



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Consent for Dental Treatment

I request and authorize Dr. John Roberts, Dr. Raenie Roberts and associated team members to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays considered necessary by Dr. John Roberts and/or Dr. Raenie Roberts to diagnose and treat my child's dental problem(s). I will allow photographs to be taken of my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. I understand that Dr. John Roberts, Dr. Raenie Roberts and team will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible of any charges incurred on this child for dental treatment. I furthermore give my permission for the following adults to accompany my child to future dental appointments and make treatment decisions concerning my child when I am not present.

Name _____ Relationship _____

Name _____ Relationship _____

Child's name _____

Child's name _____

Child's name _____

Child's name _____

Parent signature _____ Date _____