NEW BERN
FAMILY DENTISTRY

Informed Consent
Treatment of Minor
Please carefully read, ask any questions and sign below.

Minor Child Information

Print Full Name: _____ Child Date of Birth: _____
Allergies: (circle) Aspirin Penicillin Codeine Acrylic Latex
Local Anesthetics Sulfa Drugs Other: _____
Current Medications: _____
Chronic Conditions: _____

Parent, Legal Guardian or Power of Attorney Information

Print Full Name: _____
Relationship to Minor Child: _____
Contact#: _____
Additional Contact: _____

I have the legal right to authorize Dr. Debra Gong Choe, DDS, PLLC and New Bern Family Dentistry personnel to examine and perform dental treatment for the above named minor child. I request and authorize New Bern Family Dentistry and its personnel to perform dental care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed above. I understand that medical/dental advice will be relayed to the minor child on my behalf.

Limitations
Identify any specific limitations to the kinds of dental services/treatment for which this authorization is given below. If none, please state "NONE":

_____
_____

I consent to my child having dental x-rays when due and a fluoride treatment (which may or may not be covered by some insurances). **Circle one: yes no**

I understand and agree that the signatures and dates on this form will not expire without written notice or when the minor child becomes the age of 18 and that a photocopy/scanned copy of this form is considered valid as the original. By signing this informed consent, I am stating that I have read the information provided in this informed consent (or it has been read to me), and all of my questions have been answered to my satisfaction.

_____ _____
Parent, Legal Guardian or Power of Attorney Signature Date

_____
Staff Member Signature

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