the ENDODONTIC GROUP

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Parent/Guardian Consent for Endodontic Consultation, Diagnosis and/or Treatment

I, the parent and/or legal guardian (the "Guardian") of the above named patient (the "Patient"), hereby authorize the Endodontic Group, its doctors, and its assistants (collectively, the "Endodontic Group"), to perform the necessary endodontic procedures on the Patient. This consent also grants authority to the Endodontic Group to administer local anesthetics to the Patient.

It has been fully explained to me, and I understand that a perfect result is not, and cannot be, guaranteed or warranted. Both the treatment and the anesthetic procedures have been explained to me, along with possible alternative treatments, including the advantages and the disadvantages, possible risks, prognosis, and consequences of each procedure. It has also been explained to me, the risks or consequences if no treatment is provided. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherent risks of the treatment, and the alternatives to this treatment, and consent that all of my questions have been adequately answered.

I have provided the Endodontic Group, with an accurate and complete medical and personal history of the Patient, including current medications, illnesses, and any known allergies.

As the Guardian, I will be responsible for the financial obligations incurred for the dental treatment of the Patient. I understand that all fees are due in full by the completion of the treatment.

By signing below, I am voluntarily giving my authorization and consent to the performance of the procedure(s) described by the Endodontic Group.

Signed _____
(Parent or Guardian)

Authorization must be signed by the parent or guardian in the case of a minor, or when the patient is physically or mentally incapacitated.