

**DR. MELISSA M. BEAUDET-UY**  
GENERAL DENTISTRY LIMITED TO CHILDREN AND TEENS

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**MELISSA M. BEAUDET-UY D.D.S.**

Hillside Plaza  
76-6225 Kuakini Hwy. Suite A-106  
Kailua-Kona, HI 96740  
(808)329-7351

**DENTAL TREATMENT CONSENT FORM**

**Patient(s) Name(s):** \_\_\_\_\_

I, (being the parent or guardian of the above minor patient) do hereby authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Beaudet-Uy may deem necessary during treatment.

I understand that Dr. Beaudet-Uy and other authorized personnel as she may designate to treat the above named patient will use restorative, oral surgery and patient management techniques that are reasonably, necessary and advisable.

I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Dr. Beaudet-Uy.

I agree to be responsible for full payment of all charges for dental services performed on the above-named patient.

Date: \_\_\_\_\_

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Signature of Parent/Guardian/Self if over 18

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Relationship

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Witness