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

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

Hillside Plaza

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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: _____

_____

Signature of Parent/Guardian/Self if over 18

_____

Relationship

_____

Witness