Abraham & Gill, DMD, LLC
Children/Adolescent Dentistry & Orthodontics

James M. Abraham, DMD
Sean A. Gill, DMD

DENTAL TREATMENT CONSENT FORM

I, _____ being the parent or guardian of the minor patient(s),

_____ do hereby authorize and request the performance of dental services for this/these patient(s) and the use of whatever procedures Dr. Abraham and/or Dr. Gill may deem necessary during treatment.

I understand that Dr. Abraham and/or Dr. Gill and other authorized personnel as he may designate to treat the above named patient(s) will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Abraham and/or Dr. Gill. This authorization is valid until revoked by me in writing.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and I consent to my child(ren) having treatment by signing below; knowing that the treatment options may change at any time.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover, if applicable on the above patient(s).

Signature of parent
or legal guardian:_____ Date:_____

Signature of Dentist: _____ Date:_____

Signature of Witness: _____ Date:_____

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