



Samuels Dental Arts

Consent for Treatment

I am the parent or guardian of _____, who is a minor child and I authorize examination and treatment, as necessary, by or under the supervision of Dr. Peter J. Samuels and/or Dr. Julie C. Berger. This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and materials for such treatment.

I have read and understand the above information and the information given to me verbally. By my signature below, I consent to the treatment described in this paper.

Patient's or Guardian's Signature _____ Date: _____

Witness's Signature _____ Date: _____