Gail V. Plauka, D.M.D., P.C. and Associates

Pediatric Dentistry
Diagnostic and Preventive Consent

Patient's Name_________________________ Date of Birth_____________________

1. I request and authorize Gail V. Plauka, D.M.D., her associates and other health care professionals on her staff to perform or assist in the performance of regular dental care.

2. I understand these procedures involve cleanings, necessary x-rays, fluoride treatments when applicable. The purpose of these procedures is to maintain dental health, although no guarantee or assurances of any sort as to these results may be obtained.

3. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatments in terms appropriate to their age.

4. I understand if any treatment other than the above is required, it will be discussed with me before beginning such treatment.

5. I authorize the use of photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.

6. I understand I may refuse to consent to any and all treatments of procedures specified above or discussed with me. My right to refuse to consent to anything can be designated in this form by drawing a line through the objectionable word, sentence or paragraph, and writing my initials next to the portion to which I refuse to consent. I am free to indicate anything not mentioned herein, but to which I refuse to consent at the end of this form.

7. I certify that I have read the above. I acknowledge that the dentist has explained the above to me in a thorough and comprehensible manner and that my questions have been answered to my satisfaction.

__________________ Date

___________________________ Signature

__________________ Witness

____________________________ Relationship to patient