GIVE KIDS A SMILE
Limited Doctor/Patient Relationship

CONSENT TO TREATMENT

I _____, recognize that Dr. _____ is treating/examining my child today during the "Give Kids a Smile" day at my request. I realize that my child's relationship with the dentist is limited to my child's visit today. I understand that Dr. _____ is not my child's dentist, and that my child is not his/her patient.

I acknowledge that the dentist owes my child no duty to treat any dental condition my child may have, and that because of the limited time available or certain medical conditions my child might have, my child may not receive all of the dental procedures that my child requires today.

I understand that if the dentist recommends need for further treatment for my child, it is my responsibility to seek any follow-up care from my child's primary dentist, health department, family physician, or hospital emergency room if required.

I grant to the Minnesota Dental Association, the ADA Foundation, the American Dental Association, and its agents the right to use my child's and my picture, voice, and other reproductions of my child's and my physical likeness in connection with advertising and publicizing the Give Kids a Smile day program and its activities in all forms of media in perpetuity.

I have read or had read to me and understand and agree to all of the above, and based upon the above provisions, I hereby consent to the treatment of my child.

Patient Name (please print): _____

Parent or Legal Guardian Signature: _____

Witness: _____

Doctor Signature: _____

Date: _____