FORT WORTH
pediatric
DENTISTRY

JANELL I. PLOCHECK, D.D.S.

Diplomate of the American Board of Pediatric Dentistry

Consent for Treatment

Child's Name: _____ Date of Birth: _____

The undersigned hereby authorizes Fort Worth Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services using methods deemed appropriate for the care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

I understand that I am responsible for the full cost of necessary dental treatment for the above named child regardless of insurance coverage.

I understand that I am responsible for notifying this office of any accidents, major illnesses or changes in medical history of the above named child.

Signature: _____ Date: _____