Superior Endodontics
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Parent/Guardian Consent for Endodontic Consultation, Diagnosis and/or Treatment

_____ (Patient's Name) _____-_____-_____ (Patient's SS#) _____/_____/_____ (Patient's D.O.B.)

I, the parent and/or legal guardian (the "Guardian") of the above named patient (the Patient"), hereby authorize Superior Endodontics, its doctors, and its assistants (collectively, "Superior Endodontics"), to perform the necessary endodontic procedures on the Patient. This consent also grants authority to Superior Endodontics to administer local anesthetic to the Patient.

It has been fully explained to me, and I understand that a perfect result is not, and cannot be, guaranteed or warranted. Both the treatment and the anesthetic procedures have been explained to me, along with possible alternative treatments, including the advantages and disadvantages, possible risks, prognosis, and consequences of each procedure. It has also been explained to me the risks or consequences if no treatment is provided. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherit risks of the treatment, and the alternatives to this treatment, and the consent that all of my questions have been adequately answered.

I have provided Superior Endodontics, with an accurate and complete medical and personal history of the Patient, including current medications, illnesses, and any known allergies.

As the Guardian, I will be responsible for the obligations incurred for the dental treatment of the Patient. I understand that all fees are due in full by completion of the treatment.

By signing below, I am voluntarily giving my authorization and consent to the performance of the procedure(s) described by Superior Endodontics.

(Signature of Parent/Guardian) _____ Date: _____

Authorization must be signed by the parent or guardian in the case of a minor, or when the patient is physically or mentally incapacitated.