HEATHER FERAY BOHAN, DDS, PA

Parental Consent to Treat Child

Patient(s) Name: _____

Parent/Guardian Name: _____

I, _____, give my authorization for Dr. Heather Feray-Bohan and her team to treat my child/children.

I, _____, give my authorization for the following people to drop off, pick up, schedule appointments for, or make decisions in my behalf for my child/children. (Must be 18yrs of age or older) For example: siblings, grandparents, spouses, etc...

_____

_____

_____

Regarding Your Child's Dental Visit . . .

Dr. Bohan is committed to your child having a quality dental experience wherein he or she can establish a trusting relationship with our team. Because procedures can often require intense focus and great attention to detail, Dr. Bohan asks that all parents and family members kindly wait in our waiting area during all dental appointments. Your child deserves the highest quality of workmanship, and the utmost of our team's attention during their appointment. Other family members present during appointments can often be distracting for both the patient and the staff member. **Please feel assured that our first priority is making sure your child does not have a negative experience. Dr. Bohan never practices dentistry on an unwilling child.** If your child exhibits anxiety or fear, we will recommend a fantastic pedodontist (children's dentist) to take over his/her care. Children who have negative dental experiences often become adults who are unwilling to visit their dentist regularly. We *always* strive to protect the trust relationship with your child. Dr. Bohan is available prior to & following appointments to discuss any issues with you. Please sign below stating that you give your consent for Dr. Bohan and our team to treat your child, also acknowledging understanding of the above office policy.

_____ _____

Parent/Guardian Signature Date