ARIZONA CENTER
FOR LASER DENTISTRY

CONSENT FOR TREATMENT OF A MINOR

I am the parent or guardian of _____ (name of child) who is a minor child (under 18 years of age). I hereby authorize examination and treatment as necessary by and/or under the supervision of Dr. Enrico DiVito or Dr. Roberto DiVito. This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed and use of appropriate medicaments and materials for such treatment.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN TO ME VERBALLY. BY MY SIGNATURE BELOW, I CONSENT TO THE TREATMENT DESCRIBED HEREIN.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

7900 E. Thompson Peak • Suite 101 • Scottsdale • AZ • 85255 • P (480) 990-1905 • F (480) 990-2311 • www.drdivito.com