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CONSENT FOR DENTAL TREATMENT

I, _____, the parent/guardian of, _____,
do hereby authorize Dr. Tina Nguyen and licensed staff to the following dental procedures: Complete
diagnosis and evaluation, x-rays, study models, photographs or any other diagnostic aid deemed
necessary by Dr. Nguyen to make a thorough diagnosis of the patient's dental needs. I also authorize
Dr. Nguyen to perform any and all forms of treatment, medication and therapy that may be indicated
including the administration of local anesthesia and/or nitrous oxide.

Signature of Parent/Guardian

Date (DD/MM/YYYY)

Relationship to Patient