HOWARD L. EDELMAN, D.D.S.
JAMES M. STEVENSON, D.D.S.

Dresher Professional Center
830 Twining Road, Suite 9
Dresher, Pennsylvania 19025
Telephone: (215) 641-0441

CONSENT FOR TREATMENT- CHILD

I am the (parent or guardian) of ________________________________-(name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Drs. Edelman and or Stevenson. This includes exposure of radiographs as necessary, use of local anesthetics, 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 I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Parent Signature____Date_______________

Witness____Date_______________