



OPEN DOOR FAMILY MEDICAL CENTERS, INC.

<input type="checkbox"/> Ossining Open Door 165 Main Street Ossining, NY 10562 Telephone: (914)941-1263 Facsimile: (914)502-1408	<input type="checkbox"/> Sleepy Hollow Open Door 80 Beekman Ave. Sleepy Hollow, NY 10591 Telephone: (914)631-4141 Facsimile: (914)631-1867	<input type="checkbox"/> Port Chester Open Door 5 Grace Church Street Port Chester, NY 10573 Telephone: (914)937-8899 Facsimile: (914)937-7732	<input type="checkbox"/> Kennedy Magnet School 40 Olivia Street Port Chester, NY 10573 Telephone: (914)939-1163 Facsimile: (914)939-1146	<input type="checkbox"/> Edison Elementary School 132 Rectory Street Port Chester, NY 10573 Telephone: (914)939-1205 Facsimile: (914)939-1187
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Patient's Name: _____ Birthdate: _____ Chart # _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the Open Door Medical Centers. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

(print your name) (relationship) (date)

(your signature) (witness) (date)

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This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If child is over 13, please check one:

- ☐ Since my child is over the age of 13, I also give permission for him/her to present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.
- ☐ Although my child is over 13, I wish to be present for all treatments performed.

(signature of parent or legal guardian)

This consent shall be considered in effect until rescinded or revoked.