



Coconut Kids
Dentistry & Orthodontics



Patient Consent to X-Rays/Photos

I authorize the performance of diagnostic x-rays/photos of myself which Coconut Kids Dentistry & Orthodontics / Braces by Grant may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

Printed Name _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ of age. I authorize the performance of diagnostic x-ray/photos of this minor which Coconut Kids Dentistry & Orthodontics / Braces by Grant may consider necessary or advisable in the course of the examination and treatment.

Signed _____ Date _____

Females: Regarding the Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Coconut Kids Dentistry & Orthodontics / Braces by Grant has my permission to perform diagnostic x-rays during the examination and treatment.

Signed _____ Date _____

Printed Name _____

Note: If you require a copy of an x-ray, there is a duplication fee of \$55 each.