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Radiograph and Fluoride Consent Form

I Patient or Guardian name _____ parent of Child's name _____ consent Dr. Galliani / Dr. Rosenberg from Growing Smiles of Northern Virginia to (check one below):

- ◯ **Not take** dental radiographs of my child
- ◯ **Take** dental radiographs of my child

I understand that a complete diagnosis cannot be accomplished without radiographs since we cannot see some areas of the mouth clinically (especially areas in between the teeth). I am also aware Dr. Galliani / Dr. Rosenberg is not going to be able to diagnose certain dental pathologies or anomalies found in radiographs (Not limited to extra teeth, missing teeth, cysts, etc.)

Apply Fluoride? **Yes** ◯ **No** ◯

The application of Fluoride is recommended by our doctors every 6 months to strengthen the enamel and to reduce the risk of cavities.

Signature of Patient or Guardian:

Date: DD/MM/YYYY Click icon on the toolbar to add the digital signature. _____