Doctors Name
Address
City, State zip
Telephone Number

**Minor/Child Consent**

I, being the parent or guardian of _____ authorize (Doctor) to perform necessary dental treatment for my child, including but not limited to x-rays, fluoride, and administration of anesthetics which are deemed advisable by (Doctor) whether or not I am present at the actual appointment when treatment is rendered.

Please indicate any changes in the child's health, new medications, allergies and/or hospitalizations on the health history form or at the bottom of this form.

Dr. _____ has informed me of my child's dental needs and associated investment, possible risks involved and investments have been answered to my satisfaction.

**Treatment Date** _____

Estimated fee $_____

Estimated portion due on the day of service $_____

Patient/Guardian Signature _____

**Permission by another source:**

Date: _____

Name of Team Member: _____

Name of Parent/Guardian: _____