Community
Smiles Dental

CONSENT OF DENTAL TREATMENT OF A MINOR CHILD

I, (We) _____and _____
(parent name) (parent name)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of

_____; _____
_____; _____
_____; _____
(child's/children's name/s) (date of birth)

who reside/s with me (us) at

_____; _____,_____
(street address) (city) (state) (zip code)

I (We) can be reached at_____.
(phone number)

I (We) authorize _____, an adult,
(relation to patient/family)

to consent to any necessary examination, anesthetic, dental diagnosis, surgery or dental treatment and scheduling to be rendered to the above named minor under the general or special supervision and on the advice of any dentist licensed to practice dentistry in the state of Wisconsin.

Dated this _____ day of _____, 20_____
(day) (month)

_____ _____
Signature of parent or guardian Signature of parent or guardian