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

This form is valid for 2 years from the date it is signed unless rescinded by the parent or guardian verbally or in writing.