Webb City Dental

Pediatric & Family

# CONSENT FOR TREATMENT OF A MINOR CHILD

Accompanied by an adult other than parent or legal guardian

I, ______________________________

(parent or legal guardian)

Authorize Webb City Dental to treat the following child/children:

| Name & Birthdate: |
|---|
| Name & Birthdate: |
| Name & Birthdate: |
| Name & Birthdate: |

For routine and emergency dental treatment when deemed necessary by qualified dental personnel when accompanied by:

| Name and Relationship: |
|---|
| Name and Relationship: |
| Name and Relationship: |

This authorization is valid for one (1) year from the date signed unless otherwise specified in writing.

______________________________

Printed Name of Parent/Legal Guardian

______________________________ ____________________

Signature of Parent/Legal Guardian Date