MINOR/CHILD CONSENT

I, the parent or guardian of _____, do hereby request and authorize the dental staff to perform necessary dental services for my child. This includes performing x-rays, administration of anesthesia and any services deemed advisable by the doctor, even if I am not present in the operatory during the treatment.

PERMISSION TO TREAT

Because your child is a minor, it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes all necessary examinations and treatment, as well as the use of procedures the doctor may deem necessary during the performance of services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient.

FINANCIAL AGREEMENT

I acknowledge that payment is due in full at the time of treatment. I accept full responsibility for all fees and services rendered. If your account becomes past due, we will refer to an agency to collect the debt.

PARENT SIGNATURE:_____

DATE:_____