Everglades Pediatric Dentistry

Parental/Legal Guardian Consent for Dental Treatment

_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth

Authorized Caregiver's Information

_____	_____	_____
Caregiver's Name	Home Number	Cell Number
_____	_____	_____
Caregiver's Name	Home Number	Cell Number

The above named caregiver shall be authorized to consent for all dental treatment, for the above named child / children, which may be required during my absence. I agree to pay for all services provided to my child / children that the caregiver has authorized.

If circumstances permit and / or if Everglades Pediatric Dentistry needs to contact me, please contact me at the following number:_____

This consent serves as permission for treatment by Everglades Pediatric Dentistry for the above named child / children.

This authorization shall be effective until I revoke the authorization in writing and submit it to Everglades Pediatric Dentistry.

_____	_____
Parent / Legal Guardian (circle one)	Date
_____	_____
Witness	Date