CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, ___________________________________ parent or legal guardian of
(Parent or Guardian Name)

_____________________________________, do hereby consent to any dental
(Child's Name)
treatment and the administration of anesthesia, determined by the doctor to be necessary for the welfare of my child while said child is under the care of Bethlehem Smiles.

This authorization is effective as of ___________________ and will end on the
(Date)
child's 18th birthday.

Parent or Guardian Signature: _______________________________

Date: _________________________

Phone numbers where parent or guardian can be reached while child in being treated:

__________________ , _______________________ , _________________________

Emergency contact in parent or guardian unable to be reached:

Full Name: ____

Phone Number(s):____