PERMISSION TO TREAT

I (We) _____
please print name(s) of legal guardian(s)

authorize Pediatric Dentistry of Brandon, PA and its personnel to deliver dental services to my child(ren), listed below.

(please print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact in case of an emergency:

(please print)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

_____ Date:_____
Signature of Legal Guardian(s)

Relationship to Patient: _____ Primary Phone: _____