TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, ____(Parent/Guardian name),

give Gentle Touch Dentistry For All Ages, permission to treat my child, _____________

_______________ (Child's name), while I am not present.

The individual bringing my child to the appointment is named, _____________________

_______________ (Adult accompanying child) and is at least eighteen years of age and

is the patient's ______________________ (relationship to child).

I also give this individual permission to make decisions regarding my child's dental

treatment, medical treatment (if necessary should an emergency arise) and behavior

management. I understand payment is expected at the time of treatment.

Parental contact information for questions regarding treatment of the child:

Parent's Name: ____

Contact Info: (Cell) ______________________ (Home) _________________________

(Work) _______________________

Mailing Address:

____

City _____________________________ State __________ Zip Code _______________

Signed: _____________________________________ Date:______________________

Relationship to Patient: ____