



Parent's Consent for a non-legal guardian to bring a Patient to the dental office

I _____ (mother/father/legal guardian) of
Name of the patient: _____ DOB: _____
is authorizing Ms./Mr. _____ to bring my
child to the dental office of KidZone Dentistry for:

- Exam
- X-rays
- Cleaning
- Fluoride
- Restorative Treatment
- Endodontics Treatment
- Periodontics Treatment
- Palliative Treatment
- Extractions
- Analgesia
- Local anesthesia
- Behavior management

I am also authorizing Ms./ Mr. _____ to take decisions and sign for
any papers and/or consents for the dental treatment to be performed on my child and this is my written
consent.

Signature of Patient's parent/legal guardian

Date

Witness By (Print name and sign)

Date