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
- Palliative Treatment
- 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

13039 Summerfield Square Drive. Riverview, FL 33578.
Tel: (813) 677-3047. Fax: (813) 649-6376.