GENERAL & COSMETIC FAMILY DENTISTRY
3409 CALLOWAY DRIVE UNIT 402
BAKERSFIELD, CA 93312
661-387-6577

Parent/Guardian's Name: _____

I, being the parent or guardian of _____, do hereby authorize the dental staff to perform necessary dental services for my child, including administration of anesthesia and any services deemed advisable by the doctor, even if I am not present at the office during the dental treatment. I also consent to the administration of any emergency care for my child should the need arise.

_____ initial

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient.

_____ initial

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

_____ initial

I acknowledge that payment is due in full at the time of treatment. I accept full responsibility for all fees and services rendered.

_____ initial

_____ _____
Parent/Guardian's Signature Date