

PERMISSION FOR TREATMENT OF A MINOR

TO WHOM IT MAY CONCERN:

I, _____, hereby give the following persons my consent/permission to obtain treatment for my minor child, _____, Date of Birth ____/____/_____, from David E. Shapter, D.D.S..

This permission enables Dr. David E. Shapter to obtain a history, examine the child, administer anesthesia, and perform dental procedures when the child is brought in for treatment by the following people (in addition to myself).

Must be 18 years or older.

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

(PARENT/LEGAL GUARDIAN)

Date: _____

(PARENT/LEGAL GUARDIAN ADDRESS)

Phone: _____