SMITH FAMILY & COSMETIC DENTISTRY
2865 Ring Road, Suite 100
Elizabethtown, KY 42701

CONSENT TO TREAT PATIENT WITHOUT PARENT/LEGAL GUARDIAN PRESENT

(Please fill out one form per child)

PLEASE NOTE **that if there are any medical changes or medicine changes,** the parent or legal guardian ***MUST*** speak directly with the dental health provider. If no changes, please check the box next to the child's name and initial.

_____ _____ □ No changes
Child's Name Date of Birth _____please initial

_____ _____
Parent/Legal Guardian (please print) Phone Number to reach you while your child is being treated, (Cell preferred)

This consent serves as permission for treatment by SMITH FAMILY & COSMETIC DENTISTRY for the above child.

I give my authorization for all dental treatment, for the above name child, which may be required during my absence. I agree to pay for all services provided to my child.

This Authorization shall be effective until:

□ One (1) year from date signed below
OR
□ Until_____(list Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to SMITH FAMILY & COSMETIC DENTISTRY.

SIGNATURE

_____ _____
Parent/Legal Guardian(circle on) Date

Please return with child at time of appointment.