Caring Family Dentistry
93 North State Street, Suite 201
Concord, NH 03301
603-230-9719

Parent/Legal Guardian Consent for Dental Treatment
(Please fill out one form per child)

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

______________________________ ____________ ☐NO medical changes
Child's Name Date of Birth ________Please initial

______________________________ ____________________
Parental/Legal Guardian Phone Number

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This consent serves as permission for treatment by Caring Family Dentistry for the above named child.
I give my authorization for all dental treatment, (X-rays, fluoride, sealants, fillings ect) for the above named child, which may be required during my absence.

●●

This authorization shall be effective one (1) year from date signed below

This authorization will remain in effect for one year unless I revoke this authorization in writing and submit it to Caring Family Dentistry.

Signature

____ _________________
Parent/Legal Guardian (circle one) Date

Please return this form prior to your child's appointment and call the office with any questions or concern.