Dentistry for Children
1923 Chester Blvd Richmond, IN 47374
765.373.3100

Authorization for Consent of Dental Treatment

(I)(We), the undersigned, parent(s)/person having legal guardianship of _____ _____, a minor, do hereby authorize _____ _____ for the undersigned to consent to any dental treatment found necessary by Dr. Michelle H. Edwards for the minor above. This includes but not limited to; Dental exams, dental radiographs, dental sealants, dental restorative work, dental prophylaxis, dental anesthetics.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or dental care being required. It is given to provide authority to give specific consent to any and all such diagnostic treatment, restorative treatment, preventative treatment.

I am the parent, guardian or personal representative of the above named child and there are no court orders now in effect that prohibit me from signing this consent.

X_____ Date _____
(Parent/Guardian's Name)