PERMISSION TO TREAT MINOR

Child's Name: _____ *Date:* _____

I am not able to accompany my child to their scheduled dental appointment. I, (parent or legal guardian name) _____, authorize Fishhawk Family Dental to treat my child.

I authorize Fishhawk Family Dental to perform any service that is due or necessary in the treatment of my child unless otherwise noted below.

I understand that this form will need to be updated every year and that I can contact Fishhawk Family Dental at any time with any questions regarding my child's treatment.

I can be contacted at (phone number) _____.

Additional notes: _____
_____
_____

Signature of Parent or Legal Guardian: _____ Date: _____

Fishhawk Family Dental
***Email:* generalfishhawk@gmail.com**
Fax: 813-662-3024