# 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 Summerfield Family Dental to treat my child.

**I authorize Summerfield 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 Summerfield Family Dental at any time with any questions regarding my child's treatment.

I can contact at (phone number) ____________________________.

*Additional notes:* _________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Signature of Parent or Legal Guardian: ____________________________ Date: ______________


***Summerfield Family Dental***
***Email:*** **summerfieldfamilydental@yahoo.com**
***Fax: 813-677-4064***