LIANN W. DRECHSEL, DMD, PC

PEDIATRIC DENTISTRY

DENTAL/MEDICAL PERMISSION FORM

I _____________________________________ (parent or guardian's name) give my permission to

____

(person/persons authorized to bring child/children)

To seek and receive any and all dental or medical treatment, including permission to sign any and all legal papers regarding the care of my child/children. I also give permission to give informed consent for dental care. This document also certifies that the individual that I am granting permission to has knowledge of my child's recent health history and can answer basic questions asked by the doctor. This document will be binding and legal for a single visit to our office unless otherwise noted by checking the "lifetime" box or specifying a date.

Child/Children's name(s) ____

____

____

Signature of parent or guardian ____

Printed name ____

Date: ________________

Expiration date: ________________

☐ Lifetime

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