

PARENTAL CONSENT FORM

Ι,		, give	Family Dentistry	
permission to treat my child,		, on t	, on this day	
in my absence. I am fo	ully aware of the treatr	ment being done for my chil	d today.	
Treatment Planned:				
Code	Tooth #	Description	Total Fee	
I understand that on r treatment from what is will be notified if I am I understand that in the Family Dentistry will one	are occasions, treatment able to be reached at the rare event my childetermine what is best	rent information you and you until a claim has been paid ent may need to be altered. Family Dentition and the number I have provided lid needs emergency medic for my child's health and so	In the event that my child require stry will determine what is best for them. al care in my absence that	res an alternate my child and I
Parent/Guardian Signature		Date		
Print Parent/Guardian	Name			
I can be reached at phone number			in the event of an emergency.	
If you are faxing this	form, please provide ı	us with a copy of your I.D. j	for verification and protection pur	poses.
Smithfield Family Dent	istry 910 S Bright Leaf Blvd. S	Smithfield, NC 27577 Pl	# (919) 934-1333 Fax# (919) 934-4748	