LAKEWOOD
DENTAL ARTS
DENTISTRY • ORTHODONTICS

Consent for Dental Treatment of a Minor

Patient Name: _____ Date of Birth: _____

I, the undersigned parent, hereby authorize the person(s) listed below to consent to necessary x-rays, diagnosis and treatment of the above named child.

- ☐ Non-custodial Parent _____
- ☐ Grandparent(s) _____
- ☐ Adult Child(ren) _____
- ☐ Other (specify name/relation) _____

I understand that all copayments are due at the time of service and I will make all necessary financial arrangements in advance.

This grant of temporary authority shall begin immediately and shall remain in effect until terminated by the undersigned in writing.

Patient/Parent/Guardian Signature