6902 Navajo Rd
San Diego, Ca 92119
(619) 582-9700

Parental Consent for Dental/Periodontal Treatment

_____ _____ _____
Child's Name Date of Birth Age

_____ _____
Parental Contact (during appointment) Phone Number

You MUST be available by phone during your child's appointment

_____
Fax Number

This consent serves as permission for **Mission Trails Dentistry** to provide treatment for my child. I agree to all initialed services listed below provided to my child in my absence and I understand I am responsible for all charges NOT covered by insurance (if applicable). This authorization shall be in effect until: (select one)
a)_____(Month,Day Year) b)unless otherwise revoked by me.

___ Cleaning
___ Fluoride/Varnish
___ Exam
___ X-Rays
___ Restorative Treatment
___ Other: _____

FORM **MUST** BE PRESENTED AT TIME OF APPOINTMENT WITH ***ORIGINAL*** SIGNATURES

Signatures

_____ _____
Parent/Legal Guardian (circle one) Date