CONSENT TO TREAT MINOR CHILDREN

I, ________________________, parent or legal guardian of ________________________, born

the ___ day of ________________________, 20___ do hereby consent to any and all dental care including fluoride, x-rays, and the administration of anesthesia as determined necessary by Dr. Buehler of Buehler Family Dental.

This authorization is effective from the ___ day of ________________________, 20___ to

___ day of ________________________, 20___

_______________________________________ ___________________

Signature of Parent or Legal Guardian **Date**

_______________________________ _______________________________

Witness Signature Witness Name (please print)

This consent form should be taken with the child to the dental office when the child is unaccompanied by a parent or legal guardian for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address ____

Emergency Contact: ______________________________________ Phone: _________________

Allergies to drugs or foods: ____

Special Medications, Blood Type or Pertinent Information: ________________________________

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