Scott A. Jackson, DMD, MAGD
Joseph C. Joyce, DMD, MS, FAGD

CONSENT TO TREAT A MINOR

Patient: ______________________________

Date:______________

I authorize Dr. ____________________, and such assistants as he/she may designate, to render dental care to ______________________________. I consent to any dental care which encompasses diagnostic or dental treatment which my dentist or his/her designee may deem necessary for my child's dental health and well-being.

______________________________ Date: ______________
Parent/Guardian or Authorized Representative

______________________________ Date: ______________
Witness