CONSENT

Dear Parent or legal guardian,

Since my child____________________ is a minor

By (Patient Name)

It becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by wither Dr. Michele Savel and or any Doctors associated with Kiddsmiles, PLLC.

Authorization is hereby granted to do an examination, take X-rays, clean teeth, give fluoride treatment, and provide oral hygiene instructions if deemed necessary. Following a consultation, authorization is hereby granted to administer any treatment, anesthetics, extractions, and perform such operations or otherwise treat my child as it may be deemed necessary and or advisable. I also give permission to provide my child with emergency care if needed.

I authorize my pediatrician or other Physician(s)/medical facilities to release any and all pertinent medical information regarding my child.

I further understand that this consent will remain in full effect until such time that I choose to terminate it.

I understand that I accept responsibility for payment of services rendered.

I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

Signed:____Date:_______________________

(Parent or legal guardian)