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Consent for Treatment of Minor Child

I, being the parent or guardian of _____ / _____
(Patient Name) (Date of Birth)

do hereby request and authorize Chapel Hill Pediatric Dentistry and Staff to perform necessary procedures for my child which are deemed advisable by the dentist, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child in for treatment.

- Patient by him/herself if age 18 years or older.
- I do not give permission

Signature of Parent of Guardian / Printed Name

Date

Witness

Date