WHITE OAKS DENTAL

Consent to Treat Minor

This consent serves as permission for White Oaks Dental to treat my child in my absence.

I understand that I must inform White Oaks Dental of any medical changes to my child.

I give my authorization for all dental treatment including routine procedures that may be required during my absence: x-rays, exams, prophy, preventive procedures including sealants, as well as emergency dental treatment such as extractions. I agree to pay for all services provided to my child.

This authorization shall remain in effect until my child turns 18 or until I give written notice to White Oaks Dental.

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Patient Name (Print) Patient Date of Birth

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Name of Parent/Legal Guardian (Print) Signature of Parent/ Legal Guardian

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Relationship to Patient Date