Belknap Dental Associates

40 Chestnut Street, Suite 2
Dover, NH 03820
(603) 742-4735

Parental/Legal Guardian Consent for Dental Treatment

(Please fill out one form per child)

PLEASE NOTE that if there are any medical changes, the parent or legal guardian **MUST** speak directly with the dental health provider. If no changes, please check box next to child's name and initial.

_____ _____ ❒ NO medical changes
Child's Name Date of Birth _____ Please initial

_____ _____
Parental/Legal Guardian Contact (please print) **Phone Number**

This consent serves as permission for treatment by Belknap Dental Associates for the above named child.

I give my authorization for all dental treatment, for the above named child, which may be required during my absence. I agree to pay for all services provided to my child.

This authorization shall be effective until:

❒ One (1) year from date signed below

OR

Until _____ (list Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Belknap Dental Associates prior to this date.

Signature

_____ _____
Parent/Legal Guardian (circle one) Date

Please return with child at time of appointment.