CONSENT TO TREAT MINOR CHILDREN

I, ________________________, parent or legal guardian of ________________________, born

the ___ day of ________________________, 20___ do hereby consent to any dental care and the X rays determined by Dr. Katherine K. Yi to be necessary for the welfare of my child.

_______________________________________ ___________________
Signature of Parent or Legal Guardian **Date**

_______________________________ _______________________________
Witness Signature Witness Name (please print)

This consent form should be taken with the child to the dental office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address ____

Father's Telephone: _________________ Mother's Telephone: ________________

Last Tetanus: ___________________

Allergies to drugs or foods: ____

Special Medications, Blood Type or Pertinent Information: _______________________________

____

Child's Physician: ___________________________ Phone: ________________

Insurance: __________________________________ Policy # ________________

Preferred Hospital: ____

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