



Garret Family Dental Care
 15009 West Bell Road, Suite 175
 Surprise, Arizona 85374-3213
 Phone 623.476.8100
 Fax 623.792.5311
 garrettdental@gmail.com

MINOR CONSENT

I hereby authorize Garrett Family Dental to proceed with dental treatment for the following dependent(s):

NAME _____	BIRTH DATE _____
First	Last
NAME _____	BIRTH DATE _____
First	Last
NAME _____	BIRTH DATE _____
First	Last
NAME _____	BIRTH DATE _____
First	Last
NAME _____	BIRTH DATE _____
First	Last
NAME _____	BIRTH DATE _____
First	Last

WITHOUT a parent or legal guardian present, advisable by a dentist, and provided or supervised by that dentist, for the treatment listed below:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Exams | <input type="checkbox"/> Prophylaxis (<i>regular cleaning</i>) |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Periodontal Scaling and Root Planning (<i>deep cleaning</i>) |
| <input type="checkbox"/> Fluoride | <input type="checkbox"/> Resin Composite (<i>white or tooth colored fillings</i>) |
| <input type="checkbox"/> Sealants | <input type="checkbox"/> Crowns |
| <input type="checkbox"/> Anesthetic | <input type="checkbox"/> Other _____ |

CONSENT AND RELEASE

By signing below, I, the parent or legal guardians, hereby give authorization to Garrett Family Dental Care, for the treatment and procedures chosen above. I acknowledge that I have had the opportunity to discuss the patient's condition and have had the diagnosed treatment and procedures explained to me. I therefore release Garrett Family Dental Care from all liability. And in addition, I am aware that payment is still due at the time service is rendered.

X _____ **Date**

Signature of Patient or Legal Guardian

_____ **Relationship to Patient**

Print name of Patient or Legal Guardian

