DENTAL TREATMENT AUTHORIZATION AND INFORMED CONSENT FOR MINOR

I, _____, the parent or guardian of the following minor(s) do hereby authorize and consent to Bogacki and Bogacki DDS, PC and there Dental Staff to render comprehensive dental care (such as composite fillings, anterior composite crowns, steel crowns), pulpal therapies, X-rays, extractions, orthodontic appliances, cleanings, and Fluoride treatment. This authorization will remain in effect until cancelled in writing by me.

_____ _____

Minor Name Minor Date of Birth

_____ _____

Minor Name Minor Date of Birth

_____ _____

Minor Name Minor Date of Birth

_____ _____

Minor Name Minor Date of Birth

_____ _____

Minor Name Minor Date of Birth

_____ _____

Parent/Guardian Name Date

_____

Parent/Guardian Signature