Stafford Dental Care

159 Lichfield Blvd., Suite 107
Fredericksburg, VA 22406
Phone 540-373-2273
Fax 540-373-9233

Consent to Treat a Minor Child Form

Child's Name: _____
Date of Birth: _____
Address: _____
_____
_____

By my signature on this form I consent to the above mentioned child receiving routine dental procedures in my absence. I further give my permission for such services to be billed to my insurance company and I accept financial responsibility for charges and such services not covered by my insurance company. Co-payments are always due at the time of service.

Please document below who, in your absence, has the authority to authorize dental treatment for the above mentioned child.

_____ _____
First/Last Name Date of Birth

_____ _____
First/Last Name Date of Birth

Parent or Legal Guardian Name: _____

Relationship to Patient: _____

Address: _____
_____

Parent or Legal Guardian Signature: _____
Date: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Stafford Dental Care. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation.