497 West Main Street
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Ph: 513-735-9111
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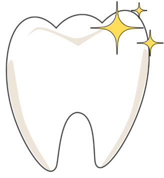

Klermont 4 Kids & Adults 2

AUTHORIZATION FOR CONSENT TO DENTAL TREATMENT OF MINOR

In my absence, I, ____________________________________ , who has the legal custody of my child,
(Parent/Legal Guardian)

____________________________________ , and whose birth date is ___________________________
(Child's name) (mm/dd/yyyy)

Authorizes _____________________________ to provide consent to Klermont 4 Kids & Adults 2, its
(Consenting adult)

Doctors and staff to render care under the supervision and advice of a licensed Dentist or other dental care professionals.

Please initial below the items you wish to allow the above individual to consent:

_________ Dental exams and treatments

_________ Surgical exam treatments

_________ Diagnostics imaging procedures

_________ Anesthetic and/or sedation procedures

By the parent/legal guardian, if requested in writing. Furthermore I state that I am authorized to grant permission for treatment for the patient listed above.

____
(Parent/Legal Guardian Signature)

____
(Date)

Special Note: For this authorization to be valid, the notary public certification below is required.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Date: __________________________ (Affix Seal Here)

State of ________________________ County of __________________________

On this date, ________________________ personally appeared before me _________________________
(Signer) (Notary)

Please initial one of the following:

_________ Personally known to me OR

_________ Proved to me on this basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed and acknowledged to me that he//she/they executed the Authorization for Consent to Dental Treatment of Minor.