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Liberty Lake, WA 99019
(509) 891-7070
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DENTAL TREATMENT CONSENT

Patient Name: ____

For the safety and privacy of our patients, we require written consent to provide treatment for a child accompanied by anyone other than their natural parent or legal guardian. If you anticipate that anyone, including a stepparent, grandparent, babysitter, etc., may bring your child for a dental visit, please complete this form. If you have questions or concerns, please call our office.

Please complete one form for each child receiving dental treatment.

I ____ , Mother / Father / Legal Guardian of the patient named

above, authorize ____ to seek and authorize treatment for dental care including routine, surgical, restorative and emergent care provided by KiDDS Dental. I also understand and agree that this consent shall remain in effect until revoked by me in writing.

Phone number where I can be contacted: ________________________ .

Signature____ Date _________________________________

Circle One: Parent Guardian