CONSENT TO TREAT MINOR CHILDREN

DATE:____________________

TO: **Orland Park Dentistry For Children**
Palos Health South Campus
15300 S. West Ave., - Suite 110
Orland Park, IL 60462
(708) 403-3330 Fax: (708) 403-5762
www.orlandparkdentistryforchildren.com

Child/Children's names	**Date of Birth**
RE: ____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

I give permission for ______________________to bring________________________ to Orland Park Dentistry for Children for any and all scheduled appointments. I also give my permission to____________________(Person accompanying child/children) to authorize radiographs and any work needed to be done during their visits. If needed you can reach me on my cell phone_________________. Please keep this letter in your records for all future needs.

Thank you,

Sign:___________________________________

Print:___________________________________

Phone:_______________________ Phone:_________________________