CRESCENT
DENTAL & ORTHODONTICS

NON-PARENTAL CONSENT TO DENTAL TREATMENT

I, ______________________________, parent/legal guardian of the child(ren) listed below do herby give authorization and consent for the authorized person(s) reflected below to consent to the authorize the dental services provided to my child(ren). I herby authorize and grant that the below named person(s) has/have permission from the natural parents for any dental care and treatment deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have authority to consentfor all dental care and treatment of said child(ren):

____________________	____________________	____________________
Signature	Relationship to child(ren)	Date

Child(ren):

____________________	____________________
Name	Name
____________________	____________________
Name	Name

Authorized person(s):

____________________	____________________
Name	Relationship to Parent or Guardian

IDENTIFICATION MUST BE ON FILE FOR AUTHORIZED PERSON(S)

____________________	____________________
Signature of Parent/Legal Guardian	Date

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Appointment Date