Dr. S. Rangrass DDS, PC

Parental Consent

I _____ give permission to:

Parent/Guardian

(Please list anyone, other than parent/guardian, who is authorized to bring your child in for treatment)

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

To authorize dental treatment for my child _____.

_____ _____

Signature Date