Consent for Treatment of a Minor

Consent for Treatment of Minor Child

Minor's Patient Information

First Name *

Last Name *

MI

I,

Name of Parent/Guardian

, being the **parent or guardian** do hereby request and authorize Relax Dental/ Dr. Rafael / Dr. Vivek and his/her staff to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Name of Minor to be treated *

First Name

Last Name *

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

☐ I consent to use Electronic Records and Signatures (Read Electronic Record and Signature Disclosure)

Relationship to patient

Name

Signature *

Date

12/04/2024