CONSENT

Dear Sir or Madam:

I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.

Furthermore, since _____is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or dental services can be started and accomplished by Dental Associates for Kids only, LLP

Authorization is hereby granted to do an examination, take appropriate x-rays, clean the teeth, give fluoride treatment and provide oral hygiene instruction if deemed necessary. Following a consultation, authorization is also granted to administer any treatment, anesthetics and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I also authorize the use of photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications. I also give permission to provide emergency care if needed.

I authorize my physician (pediatrician) and any hospital (if my child has been hospitalized) to release and all pertinent medical information.

I further understand this consent will remain in effect until such time that I choose to terminate it.

I understand that I accept responsibility for payment of services rendered.

SIGNED:_____DATE:_____

(Parent or legal Guardian)