Kenneth Arnt, D.D.S., LLC

Informed Consent

Permission for Dental Examination and/or Treatment of a Minor

I am the parent or guardian of _____,
who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Arnt and his/her associates, staff members, or agents, as he/she may deem necessary.

The following people have my permission to make necessary decisions regarding dental treatment if I am unavailable or not in attendance with my child.

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

This authorization will remain in effect until cancelled in writing by me.

Parent Signature_____ Date_____

Witness _____ Date_____