RURAL HEALTH, Inc.
We specialize in you

DENTAL CONSENT FORM FOR MINORS

I _____ authorize the following people to
(legal guardian)

accompany _____for dental treatment, including but not
(minor)

limited to fillings and extractions, and discuss further treatment.

1. _____ Relationship to Patient _____

2. _____ Relationship to Patient _____

3. _____ Relationship to Patient _____

4. _____ Relationship to Patient _____

5. _____ Relationship to Patient _____

_____ (Photo ID Required)
Name (printed)

_____ _____
Signature Date

_____
Relationship to Patient

A PHOTO ID IS REQUIRED FOR EACH AUTHORIZED PERSON AT THE TIME OF VISIT