



kneeland dental care

## CONSENT FORM FOR TREATMENT WITHOUT PARENT/GUARDIAN

I, \_\_\_\_\_, give Kneeland Dental Care, LLC permission to treat my child,  
Parent/Guardian name

\_\_\_\_\_, while I am not present. The individual bringing my child to the  
Child's name

appointment, \_\_\_\_\_ and is at least 18 years of age and is the patient's  
Name if adult accompanying child

\_\_\_\_\_  
Relationship to child

I  give this individual permission or  DO NOT give permission to make decisions regarding my child's treatment, medical treatment (if necessary should an emergency arise), and behavior management.

I understand payment is expected at the time of treatment.

### Parental contact information for questions regarding treatment of the child:

Parent's Name: \_\_\_\_\_

Contact Info: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_