KAMITI U. HARDEN,DDS, Pediatric Dentist

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TREATMENT CONSENT FOR MINORS

TO: PARENT OR LEGAL GUARDIAN

IN ORDER TO COMPLY WITH SIMPLY CHILDREN'S DENTISTRY, INC IN PROVIDING TREATMENT TO MINORS (CHILDREN UNDER AGE 18) IN YOUR ABSENCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT/CHILD:_____

I HEARBY ACKNOWLEDGE THAT I AM AWARE OF AND PROVIDE CONSENT TO THE DENTAL TREATMENT AND PROCDURE(S) TO BE PERFORMED BY DR. K. HARDEN OF SIMPLY CHILDREN'S DENTISTRY,INC.

I HEARBY ACKNOWLEDGE THAT THE ABOVE SAID MINOR CAN ONLY BE AT THE OFFICE FOR THE DURATION OF THE TREATMENT PERIOD DURING BUSINESS HOURS.

I HEARBY AUTHORIZED_____ TO SIGN AND OVERSEE ANY TREATMENT FOR_____(PATIENT/CHILD).

_____(PARENT/LEGAL GUARDIAN)