KENT ISLAND
PEDIATRIC
DENTISTRY

APPOINTMENT CONSENT:

I give consent for my child (ren) to be brought to their dental appointments by the following person or persons listed below. I give consent to Kent Island Pediatric Dentistry to share any information with individual (s) listed regarding my child's dental needs.

PLEASE CIRCLE THE FOLLOWING:

This person can complete forms on my behalf and make any decision's regarding my child's dental needs. YES OR NO

The person listed below can authorize any x-rays to be taken on my child or application of fluoride. YES OR NO

This person listed below can schedule appointments or cancel appointments on my behalf. YES OR NO

I give consent for Kent Island Pediatric Dentistry to leave me voicemail messages regarding my child's dental visit. YES OR NO

PLEASE LIST THE INDIVIDUAL TO WHICH THIS APPLYS:

NAME: _____ RELATIONSHIP TO CHILD _____

NAME: _____ RELATIONSHIP TO CHILD _____

NAME: _____ RELATIONSHIP TO CHILD _____

Parent/Legal Guardian Signature: _____ Date: _____

Childs or Children's Name: _____