**3023 Eastland Blvd, Suite 112**
**Clearwater, FL 33761**
**(727)797-5161, Fax (727)797-5121**

**Date____________________**

**I,________________________________________, parent or legal guardian of**

**_______________________________________, born __________, do hereby consent to dental care/treatment to be determined necessary by the dentist for the welfare of my child while said child is under the care of Dr. Jill, Hagan, Dr. David Wagner or Dr. Saravanah Karunagaran, as I am not reasonably available to be on site at the time of the appointment.**

**The authorization is from __________ to ____________.**
**I would request to be contacted by phone and notified of treatment recommendations?**

**Yes_________ No____________**

**If yes, the best contact number to reach you at the time of the appointment____________________________**

**Any additional information we need to know to better treat your child?**

___________________________________________________________________

___________________________________________________________________

**Signature of Parent or Legal**

**Guardian____________________________________**