MY KIDZ DENTIST

"Dentistry and Orthodontics for Children and Teenagers"

1515 E. Bethany Home Road
Suite 140
Phoenix, AZ 85014
(602) 995-7336
Fax: (602) 995-2665

9305 W. Thomas Rd.
Suite 580
Phoenix, AZ 85037
(623) 474-2470
Fax: (623) 474-2477

19636 N. 27th Ave.
Suite 403
Phoenix, AZ 85027
(623) 879-8866
Fax: (623) 298-0386

CONSENT FORM

The following person(s), including step-parents, grandparents, family members, or friends of at least 18 years of age, have my permission to bring and give consent for **treatment changes for:**

Patient's Name: _____ D.O.B. ____/____/_____
Patient's Name: _____ D.O.B. ____/____/_____
Patient's Name: _____ D.O.B. ____/____/_____
Patient's Name: _____ D.O.B. ____/____/_____
Patient's Name: _____ D.O.B. ____/____/_____

to My Kidz Dentist, for dental care and treatment(s). The person(s) listed below can also receive dental advice; will be able to pick up necessary prescriptions other than controlled substances, x-rays; Inquire and receive financial information concerning the above patient in person or over the phone.

Name: _____

Address: _____
City: _____
State: _____ Zip Code: _____
Relationship: _____
Phone: (_____) _____ - _____

Name: _____

Address: _____
City: _____
State:_____ Zip Code: _____
Relationship: _____
Phone: (_____) _____ - _____

_____

(Signature of Parent or Legal Guardian)

Date: _____/ _____ /_____