SEASIDE DENTAL CENTER

2660 NC Highway 210 East, Suite 103 Hampstead, North Carolina 28443
Tele: 910.541.2155 ~ Fax: 910.541.2174 Email: sdcsurfcity@gmail.com

I, being legal guardian of _____, do hereby give permission for the following person(s) to bring _____ to dental appointments and to allow SeaSide Dental Center to perform any dental services in my absence. I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth. I give my permission to the dentist to make any/all changes and additions as they find necessary.

I also authorize the following person(s) to make any/all necessary decisions, medical or otherwise, if a medical emergency arises.

_____ _____
Print Name Relationship to child

_____ _____
Print Name Relationship to child

_____ _____
Print Name Relationship to child

_____ _____
Print Name Relationship to child

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____