

CHRISTINA P. MILLS, DDS
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Culpeper, VA 22701
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Parental/Legal Guardian Consent for Dental Treatment
(Please fill out one form per child)

PLEASE NOTE that if there are any medical changes, the parent of legal guardian **MUST** speak directly with the dental health provider. If no changes, please check the box next to the child's name and initial.

Child's Name _____ Date of Birth _____ NO Medical Changes
Please initial

Parent/Legal Guardian Contact (please print) _____ Parent's Contact Number _____

THIS FORM APPLIES TO ALL FUTURE SERVICES THROUGH AGE 17 : _____
(Date)

PLEASE INITIAL ALL THAT APPLY BELOW (we will make every effort to follow insurance guidelines)...

Fillings _____

Prophylaxis (Cleaning) _____
(this may include General Supervision w/hygienist)

Fluoride Treatment _____

X-rays _____

Sealants _____

Other _____

THIS CONSENT SERVES AS PERMISSION FOR TREATMENT BY CHRISTINA MILLS, DDS FOR THE ABOVE NAMED CHILD DURING MY ABSENCE. I AGREE TO PAY FOR ALL SERVICES PROVIDED TO MY CHILD.

Parent/Legal Guardian Signature (circle one) _____ Date: _____

Please return with child at time of appointment.