YOUNG
DENTISTRY

Non- Parent Consent Form

Child Name	Date of Birth
Authorized Caregiver Full Name	Phone Number

I authorize Young Dentistry consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. The undersigned may also agree to any financial obligations on behalf of the parent/legal guardian.

Parent/Legal Guardian Name	Phone number
Parent/Legal Guardian Signature	Date