Martin DDS, PLLC
140 7th Ave
South Charleston, WV 25303

Parental Consent

Date:

Pt first n

Pt last name

Pt DOB

If the situation arises that I am not able to be at a dental appointment with my child. I give permission to the people listed below to bring and make medical/dental treatment decisions for my child, This will remain in effect unless revoked by myself in writing.

_____

_____

_____

Signature