Pediatric DENTISTRY
MICHAEL J. VON GRUBEN, DDS

Parent/Guardian Consent

I, _____, Custodial Parent of

_____,

(Minor/Minors)

Authorize Dr. Michael Von Gruben and their employees to render

dental treatment to the above listed child/children.

If I am unable to attend any appointments with my child(ren), the names listed below are authorized to bring them to their appointments and to discuss my child(ren)'s dental care. I also give them permission to make treatment and financial decisions.

Person's Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/ Guardian Signature:_____

Date:_____