Taylor Family Dentistry, LLC

JENNIFER E. TAYLOR, DDS

Consent to Treat a Minor

Today's Date: _____

Minor's Name: _____ Minor's DOB: _____

I, _____, hereby give my consent for my child to be examined and/or receive dental treatment by Taylor Family Dentistry, LLC. Furthermore, I hereby give my consent for my child to have any/all dental treatment completed as deemed necessary by the treating provider at the time of their appointment. Lastly, I hereby agree to accept responsibility for the payment of any/all charges incurred by my child and understand that this agreement shall remain in effect until the account is paid in full.

_____ _____

Parent / Legal Guardian *(Please Print)* Parent / Legal Guardian Signature

_____ _____

Relationship to Minor Parent / Legal Guardian's Phone Number

4834 SOCIALVILLE - FOSTER ROAD · SUITE 40 · MASON, OHIO 45040

OFFICE: (513) 229 – 7801 · FAX: (513) 229 - 7802