DAVID E. SHAPTER, D.D.S. *Pediatric Dentistry*

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128 W. 12th Street
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PERMISSION FOR TREATMENT OF A MINOR

TO WHOM IT MAY CONCERN:

I, ____, hereby give the following persons my consent/permission to obtain treatment for my minor child, ______________________________,
Date of Birth _____/ _____/ ________, from David E. Shapter, D.D.S..
This permission enables Dr. David E. Shapter to obtain a history, examine the child, administer anesthesia, and perform dental procedures when the child is brought in for treatment by the following people (in addition to myself).

Must be 18 years or older.

Name: ______________________ Relationship to Patient: __________ Phone:_______________

Name: ______________________ Relationship to Patient: __________ Phone:_______________

Name: ______________________ Relationship to Patient: __________ Phone:_______________

____ **Date:** ___________________
(PARENT/LEGAL GUARDIAN)

____ **Phone:** __________________
(PARENT/LEGAL GUARDIAN ADDRESS)