MINSTER DENTAL CARE

DATE OF SERVICE: _____

Patient Name:

_____

Date of Birth: _____/_____/_____

I, _____ (Parent/Legal Guardian) give Minster Dental Care consent to treat the above listed patient. Treatment may include but is not limited to: Intra Oral X-ray, Panoramic X-Ray, CBCT, Restorative Filling, Local Anesthetic, Nitrous Oxide, Crown, Pulpotomy, and Extraction.

SIGNATURE DATE