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Informed Consent
Permission for Dental Examination and/or
Treatment of a Minor

I am the parent or guardian of _____
Who is a minor child, and I do hereby authorize and consent to any x-ray, examination,
anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect
supervision of Dr. Pichardo and his/her associates, staff members, or agents, as she may
deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Parent Signature _____ Date _____

Witness _____