



CHILD RELEASE / TREATMENT FORM

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I, _____ authorize **Estrella Falls Dentistry** to release my child to the following people:

I, _____ authorize **Estrella Falls Dentistry** to proceed with the treatment of my child based on the agreed treatment plan.

As a courtesy, you will be notified by phone should any changes in my child's treatment plan occur. The best telephone number to reach you is _____

Parent / Legal Guardian Signature

Date

