CONSENT FOR TREATMENT OF A MINOR

The undersigned hereby authorizes Dr. McAnthony to perform the examination including x-rays, and after explanation, all forms of treatment, medication and therapy indicated for the dental care of the above named child. This consent shall remain in force and effect until cancelled by either party.

_____ _____

Signature of Parent/Guardian Date

AUTHORIZATIONS AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health, and it is my responsibility to inform the dental office of any changes in my child's medical status.

_____ Initial

I authorize Dr. McAnthony and her staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

_____ Initial

I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents whether or not charges are paid by insurance.

_____ Initial

I have read and have had any questions I may have had concerning any of the above statements answered to my complete understanding.

_____ Initial

I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Parent/Guardian Date