Williamson Pediatric Dentistry
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CONSENT FOR TREATMENT OF MINOR CHILDREN

I, parent/ legal guardian of _____, born on _____, do hereby consent to any dental care to be determined necessary by Dr. C. Andrew Williamson, DMD, MSD, for the welfare of my child's oral health while said child is under the care of:

_____ _____
Name of caretaker Caretaker's relationship to patient

This consent is given as I am unable to be with my child/children during their dental appointment. The above listed caretaker is also allowed to sign necessary forms on my behalf.

This authorization is effective for the following date/s _____.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Relationship to Patient Witness Name

_____ _____
Doctor's Signature Witness Signature