



Parental Consent for Treatment

I, _____ understand that by signing this document I give consent for
(Parent/Guardian Name)

_____ who is accompanying my child/children _____
(Accompanying Adult Name) (Child/ Children Name(s))

to their dental appointment for treatment at Wilderness Station Pediatric Dentistry. I understand that if changes in treatment occur, indicated by Dr. Marty, a team member will attempt to contact me regarding said change. I am aware that if I am not reachable at the time of the phone call, the person accompanying my child will be informed and will be asked for permission to proceed. Lastly, by consenting to this document, I understand that I am the responsible party for any payment that is due for this appointment.

Please select one:

- I will call Wilderness Station Pediatric Dentistry at (402)420-8020 to provide all updated information and provide payment in advance of the appointment
- The adult accompanying my child will provide payment at the time of service

Please provide a phone number we will be able to reach you at during the appointment time for your child/children _____
(Phone Number)

Please leave any questions or concerns that you might have for this appointment:

Parent/ Legal Guardian Signature

Date