CONSENT TO BRING

______________________________________ ____________________
Patient Name Patient Birthdate

______________________________________ ____________________
Patient Address City/State/Zip

____
Name of Authorized Person

I give my consent to the above named individual to bring the child (patient) named above to Children's Dental of Winona. I give them permission to make decisions regarding their dental treatment, possible changes or additions to treatment, behavior management and medical treatment (if necessary should an emergency arise).

I understand that the consent will remain in effect until I personally request it be revoked in writing.

____
Guardian Name (please print)

____
Guardian Signature

Children's Dental of Winona/150 E 4th Street/Winona, MN 55987
P: 507-452-1543/F: 507-452-6874
Secure Email: cdowsecure@gmail.com