ENGELBRECHT FAMILY DENTAL, P.A.
7650 Currell Blvd., Suite 300
Woodbury, MN 55125
Telephone (651) 730-9266
Fax (651) 578-0444

Permission for Dental Examination and/or Treatment of a Minor:

Patient Name: ____

Date of Birth: ____

I am the parent or guardian of patient, who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Chad Engelbrecht and his associates, staff members, or agents, as he may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

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Guardian’s Signature Date

____

Printed Name