CHILD'S NAME **CHILD'S NAME**

CHILD'S NAME **CHILD'S NAME**

CONSENT

I hereby grant authority to Dr. Fishman and his legally qualified auxiliaries to utilize x-rays, anesthetics, pre-medications, preventive and restorative procedures as may be necessary or advisable in the diagnosis and treatment of my child's dental condition. I understand that I will be consulted before any treatment is rendered.

PARENT'S SIGNATURE **DATE**

CANCELLATIONS

I understand that a minimum of 24-hour notice is required to cancel or change a dental appointment. I also understand that a $25.00 broken appointment fee will be applied to my account if the cancellation occurs without a 24-hour notice. I agree to remit the fee within one week, and no further appointments will be rescheduled until the balance is cleared. I also recognize that our office will consider waiving the fee if the broken appointment is a result of a sickness.

PARENT'S SIGNATURE **DATE**