TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _______________________________, give **GARY SICKLES, DDS** permission to treat my child, ________________________________, while I am not present.

The individual bringing my child to the appointment is named,

______________________, and is at least eighteen years of age and is the patient's _________________________________. ***I also give this individual permission to make decisions regarding my child's dental treatment, medical treatment (if necessary, should an emergency arise) and behavior management.***

I understand payment is expected at the time of treatment.

Parental contact information for questions regarding treatment of the child:

Parent's Name:________________________________

Cell: _____________________

Work:_____________________

Home:____________________

Email:_____________________

Signed:____

Date:____________________________________

Relationship to Patient:____