PEDIATRIC DENTAL PROFESSIONALS

AUTHORIZATION TO TREAT

_____

NAME OF PATIENT

I authorize Dr. Danny D. Watts to perform a complete dental examination and take any necessary radiographs (x-rays).

_____

Signed Date

_____

Relationship

I authorize Dr. Danny D. Watts to perform a complete dental examination, dental prophylaxis (cleaning of the teeth) with a topical fluoride application and take any necessary radiographs (x-rays).

_____

Signed Date

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Relationship