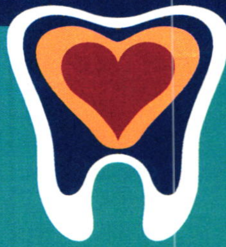

RiverValley PEDIATRICDENTAL SPECIALISTS

Rena J Christman, DMD, MPH *Pediatric Dentist*

I__________________________ the legal guardian/parent of ____________________________ (minor child) grant full permission to _________________________________ (Name/Relationship to child) to make decisions on my behalf regarding all dental treatment including, but not limited to: Fluoride, Prophy, Sealants, Radiographs, Nitrous Oxide, Fillings, Crowns, Extractions, Papoose Board. The above named person(s) can receive confidential patient information and consent to treatment of the above named minor child.

__________________________________ ______________

Signature of Parent/ Legal Guardian Today's Date

__________________________________ ______________

Signature of RVPDS Representative Date Received

425 W Prairie View Road • Chippewa Falls, WI 54729
Ph: 715.861.7901 • F: 715.861.7905 • rvpds@christman4kidsteeth.com • christman4kidsteeth.com