Reid & Reid
Pediatric Dentistry • Orthodontics

# CONSENT TO TREATMENT

I, as parent/legal guardian of _____, agree to diagnostic procedures and dental treatment as found necessary and desirable by Richard B. Reid, DDS and/or Alison C Reid, DDS, MS for the patient named above.

_____, who will accompany my child to his/her appointments, has my permission to make treatment decisions on my behalf. I have also informed him/her that he/she may be required to pay for services at the time they are rendered dependent upon my dental insurance benefits and any prior financial arrangements I have made with Richard B. Reid, DDS and/or Alison C. Reid, DDS, MS.

Parent/Legal Guardian_____

Date_____

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