Amanda S. Green, DMD
763 East Main Street
Spartanburg, SC 29302

PERMISSION TO TREAT IN ABSENCE OF PARENT OR LEGAL GUARDIAN

I, _____, hereby certify that I am the parent or legal guardian of _____.

(If being signed by a legal guardian, we need a copy of the legal document which states you are the legal guardian of this minor.)

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I give permission for Dr. Amy Green, DMD to treat the child/minor in my absence. This means we will see the patient if he or she is brought by someone other than parent or legal guardian (such as grandparent, aunt, uncle, friend, relative, etc.).

_____ I do not give my permission for Dr. Amy Green, DMD to treat this child/minor in my absence. This means we will not see the patient if he/she is not accompanied by parent of legal guardian.

Signature _____ Date: _____

Witness _____