SHAHNAZ B. AHMED D.D.S.
956 Kehrs Mill Road, Ballwin, MO 63011

MINOR CONSENT

Child's Full Name: _____

Child's Date Of Birth: _____

I, _____, give _____
(Parent or Legal Guardian) (Authorized Person Full Name)

permission to accompany my child to West County Pediatric Dentistry Services, LLC for dental appointments. I also give permission to

_____ to make any necessary decisions
(Authorized Person Full Name)

regarding dental treatment for my child, including but not limited to:

- the consent for this authorized person to sign any and all forms required to give permission to West County Pediatric Dentistry Services, LLC to treat the dental needs of my child.
- the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with this authorized person,
- the consent to the dental practice to discuss my child's future dental treatment needs, (i.e. treatment plans),
- the consent for this authorized person to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child,
- the consent for this authorized person to schedule future dental visits for my child.

I understand this consent will be valid for one year or until I rescind this agreement in writing.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
West County Pediatric Dentistry Services, LLC Date