Michael R. Callahan, D.M.D., P.C.

DENTISTRY

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CONSENT FOR TREATMENT

I am the (parent or guardian) of ______________________________(name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. Michael Callahan. This includes exposure of radiographs as necessary, use of local anesthetic, and use of appropriate medicaments and materials for such treatment.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

____
Signature Date

____
Witness Date